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ABSTRACT

This report summarizes a study conducted by the New York Family Services Project (NYFSP) of Bank Street College. The study's principal objectives were the following: (1) to document the developmental status of preschool-aged homeless children in comparison to a group of poor housed children, and the special contribution of exposure to early childhood education within both groups; (2) to document the perceived service needs of both housed and homeless families, the availability and effectiveness of those services, and the factors that may confound service delivery; and (3) to determine the interrelationships among young children's developmental status, maternal depression, characteristics of family social networks, families' perceived service needs and access to services, and housing status. The sample for the study was comprised of 160 three- , four- , and five-year-old children and their families, roughly half of whom were recruited from New York City emergency shelter facilities and half of whom were situated in some kind of permanent housing but depended on public assistance. Findings indicated few differences between homeless families living in shelters and hotels and low-income families in terms of child and family outcomes. The report includes 15 tables and 9 figures, a list of 103 references, and six appendixes. (AF)

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ILL FARES THE LAND:

THE CONSEQUENCES OF HOMELESSNESS AND CHRONIC POVERTY FOR CHILDREN AND FAMILIES IN NEW YORK CITY

Janice Molnar
William R. Rath
Tovah P. Klein
Cynthia Lowe
Annelie H. Hartmann

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"...America can't go anywhere without helping poor people. That's part of your conscience. That's how you touch God."

(A resident of a New York City emergency shelter for homeless families)

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ILL FARES THE LAND:

THE CONSEQUENCES OF HOMELESSNESS AND CHRONIC POVERTY FOR CHILDREN AND FAMILIES IN NEW YORK CITY

INTRODUCTION

This report offers an account and summary of a study conducted by the New York Family Services Project (NYFSP) of Bank Street College. The study was designed to explore the relationships among child development, family functioning, support services, and the conditions of chronic poverty and homelessness.

KEY QUESTIONS AND OBJECTIVES

In conception and design, the study addressed five key questions:

(1) How does homelessness affect family functioning in general and the development of young children in particular?

(2) What effect does the physical and emotional stress of homelessness have on a family's social networks, routines, mental health, and overall ability to cope?

(3) How do support services (both private and public) work for families who are homeless: are they accessible, appropriate, effective?

(4) In particular, does early childhood education have an impact on homeless children?

(5) What are the answers to the above questions for housed families -- that is, if "chronic poverty" were substituted for "homeless/homelessness" in each question? Specifically, what similarities and differences characterize housed and homeless families, respectively, where chronic poverty is a common denominator?

These questions, in turn, framed the principal objectives of the study:

- To document the developmental status of preschool-aged homeless children in comparison to a group of poor housed children, and the special contribution of exposure to early childhood education within both groups.
- To document the perceived service needs of both housed and homeless families, the availability and effectiveness of those services, and the factors which may confound service delivery.
- To examine the interrelationships among the following: young child's developmental status; maternal depression; characteristics of family social

networks; families' perceived service needs and access to services; and housing status (homeless or housed).

This study focused on families with young children for two reasons. First, early childhood is a period during which families have a major impact on children's development. Thus, when families are in distress, unless there is appropriate intervention and support, the likelihood is great that their children will suffer from the experience but especially families with young children. Second, chronic poverty and homelessness are deeply disturbing problems afflicting this country. In New York City, which was the site of this study, over one-third of families with children live below the poverty level (Rosenberg, 1989). On December 31, 1990, 3,860 families, including 6,800 children, were homeless and living in emergency shelter in New York City (City of New York Human Resources Administration [HRA], 1990, December).

METHODS

The sample for the study was comprised of 160 3-, 4-, and 5-year-old children and their families. Roughly half the families were recruited from New York City emergency shelter facilities. The other half, intended as a comparison group, were situated in some kind of permanent housing, but dependent on public assistance for support at the time of the study. The racial/ethnic distribution of the sample approximated that of families in the New York City emergency shelter system as a whole -- two-thirds black and 30% Hispanic, with a small minority of white and Asian families.

Primary data collection was accomplished through an interview -- conducted by teams of two interviewers -- with the mother and target child from each family. Mothers were asked to respond to a series of seven questionnaires/instruments, while the target child was administered a short developmental screening test. To ensure as broad a representation as possible of both housed and homeless populations, families were recruited from a total of 13 different sites scattered around the Borough of Manhattan, including food pantries, early childhood education programs, tenant organizations, a variety of emergency shelter facilities, and health care services. Data collection occurred between April and November, 1989. (A complete account of the study's sample, recruitment strategies, methods, measures, and data collection protocol is presented in the next chapter.)

RATIONALE FOR THE STUDY

It seems almost redundant to argue the merits of a study of homeless families and children. Since late 1987, media coverage of the escalating spiral of homelessness has been intense. Politicians have expressed virtually universal concern for the welfare of homeless populations -- especially families and children -- and dismay at the socioeconomic implications of homelessness. Moreover, as early as 1986, a Louis Harris poll reported that 88% of all Americans surveyed would be willing to pay higher taxes if they were used exclusively to provide expanded services, such as health care and day care, for children living in severe poverty (Louis Harris and Associates, 1986).

In short, there is ample evidence of widespread concern for the plight of the homeless, and both public and private sentiment appear to favor some form of substantial governmental intervention on their behalf. Ordinarily, it is at this kind of sociopolitical juncture that the work of social scientists and researchers is most welcome in the public domain. Yet, just as substantive, cohesive nationwide efforts to help the homeless have failed to materialize, so too has much needed research. This study was intended to fill part of the need for information on the impact of homelessness on young children and their families.

SUMMARY OF RESEARCH TO DATE

Although the body of research that focuses on the effects of homelessness on children and families is comparatively small, it is characterized by a consistent theme: women and children who are homeless are shown to be not simply "at-risk," but to suffer specific physical, psychological, and emotional damage due to the circumstances that usually accompany episodes of homelessness for families and children. (See Molnar, 1988; Molnar, Rath, & Klein, 1990; and Rafferty & Shinn, in press; for detailed reviews of the literature.)

The following is a brief review of the research findings on child health, child development in general, family functioning, and service linkages.

Child Health

Health, as the non-negotiable bottomline for optimal child development, has been the most frequent focus of research on the effects of homelessness on children. The findings are simple and direct:

(1) *Children who are homeless are not in good health.* While their illnesses are not atypical of children's illnesses in general, homeless children are sick at rates

many times higher than the average child. Compared to a national sample of the ambulatory pediatric population, homeless children aged birth to 12 years are twice as likely to be treated for minor upper respiratory infections and ear infections, at least three times as likely to be treated for gastrointestinal problems, four times as likely to be treated for skin ailments, and ten times as likely to be treated for poor dentition, according to data gathered by the National Health Care for the Homeless Project in 19 major cities (Wright, 1989; Wright, Weber-Burdin, Knight, & Lam, 1987). They were also almost twice as likely to exhibit one or more chronic health problems such as cardiac disease, peripheral vascular disorders, endocrine dysfunction, and neurological disorders. The same patterns of illness have been reported in local studies: Miller & Lin (1988) in Seattle; Redlener (1988), and Scanlan and colleagues (1988) in New York City.

(2) *Preventive health care is inadequate.* Immunization rates, for example, have been found to be lower among children living in shelters than among comparable groups of low-income, housed children (Acker, Fierman, & Dreyer, 1987; Alperstein, Rappaport, & Flanigan, 1988; Lee, et al., in press). Worse are data on prenatal care. In a New York City study of babies born between January 1982 and June 1984, 40% of a sample of homeless women living in so-called "welfare hotels" did not have even minimal prenatal care, compared to 15% of low-income women living in housing projects, and 9% of all New York City women (Chavkin et al., 1987). The same study documented that one out of six of the homeless mothers, or 16%, delivered a low-birthweight baby, as compared to 11% of the public housing residents and 7% of all others. Finally, the researchers found an infant mortality rate of 24.9 per 1000 among their homeless sample; this was half again as large as the rate of 16.6 in the public housing group, and double the rate of 12.0 for all other babies born in New York City during the study period.[1]

(3) *Access to health care is limited.* Access to adequate health care is problematic for poor people in general, and poor children in particular (Wright, 1989). Although appropriate comparative data are lacking, the disruption that accompanies homelessness can only make access to regular health care even more difficult. A study conducted in the Seattle area found that almost 60% of a sample of 158 homeless children living in shelters had no regular health care provider, and

---

[1] The overall U.S. infant mortality rate of 10.1 per 1000 in 1987 was higher than that of 19 countries including even less industrialized countries such as Singapore and Hong Kong (Chiles, 1990).

used emergency rooms at a rate that was two to three times higher than the U.S. general pediatric population (Miller & Lin, 1988).

(4) *The shelter environment compromises healthy development.* Unsanitary and overcrowded living conditions and poor nutrition, combined with under- or non-immunization, create breeding grounds for infectious and communicable diseases (Gross & Rosenberg, 1987). Poorly maintained shelter environments frequently expose children to a wide array of environmental hazards. For example, Alperstein et al. (1988) documented a greater number of cases of elevated lead levels among homeless children in New York City than among a low-income comparison group.

Finally, nutrition is often inadequate. Because most public shelters are not equipped with cooking facilities, families are forced to cook on illegal hot plates, eat at fast-food restaurants, and/or subsist on junk food. Moreover, supplemental food programs are not always available to all who need them. A 1987 survey of 2,112 individuals living in New York City shelters found that 49% of those who were eligible for food stamps were not receiving them (U.S. House of Representatives, 1987). In another New York City study, of families with a pregnant mother or newborn who were eligible for food through the federally funded Supplemental Food Program for Women, Infants, and Children (WIC), only 44% of 385 homeless families seeking emergency shelter were receiving benefits, compared with 60% of 83 families randomly sampled from the citywide public assistance population (Knickman & Weitzman, 1989). The potential consequences are suggested by data from yet another study conducted in New York City (deHavenon, Benker, & Boone, 1990). Twenty of 40 pregnant women interviewed while they were applying for emergency shelter reported a daily caloric intake of 800 calories or less (one-third of the 2,200-2,300 daily caloric intake recommended for pregnant women). Clearly, even before birth, children's development is being jeopardized.

General Child Development

It has been shown that children who are environmentally at risk, whose early childhood opportunities for health care, as well as opportunities for physical, social and adaptive stimulation are limited, present a high risk for future developmental delay, including mild retardation, delayed motor milestones, and restricted expressive and receptive language abilities (Meisels & Anastasiow, 1982). Although there is a paucity of systematic data focusing specifically on the general cognitive and socioemotional development of homeless children, what exists is unsettling.

Bassuk and Rosenberg (1988, 1990) found that within a sample of 86 homeless children in six Boston shelters, 54% of the 48 children under age six exhibited at least one serious impairment in language, social skills, or motor development, as measured by the Denver Developmental Screening Test (DDST), compared to a rate of 16% among a comparison group of 75 low-income housed children. Two other studies, although lacking comparison groups, have used the DDST to assess development among preschool homeless children. Wagner & Menke (1990) found that 44% of 162 homeless preschoolers in Ohio exhibited at least one developmental delay on the DDST; 24% exhibited at least two. Though the rates of delay were considerably lower, Wood et al. (1990) found that in Los Angeles 15% of homeless preschoolers manifested at least one developmental delay on the DDST; 9% indicated at least two. All three studies found the highest rates of delay in language. Since the DDST is known to under-refer children at risk at unacceptably high rates, (Meisels, 1989), results for all three studies may, in fact, underestimate the actual rates of developmental lag.

Using other instruments, similar findings were documented in a sample of 24 children under the age of five living in a St. Louis shelter who demonstrated severe language disability and impaired cognitive ability when tested using the Slosson Intelligence Test-Revised and the Peabody Picture Vocabulary Test (PPVT)-Revised (Whitman et al., 1990). Rescorla et al. (in press) in Philadelphia also used the PPVT to assess a sample of homeless preschoolers and 20 low-income housed children of the same age. Both groups scored significantly below the population mean, with homeless preschoolers scoring significantly lower than the comparison group. Homeless children also performed significantly worse than the housed children on the Beery Test of Visual Motor Integration. However, both groups were statistically indistinguishable in their performance on the Stanford-Binet Vocabulary subtest, the Cubes Test (Revised Yale Developmental Schedules) and the Draw A Person Test. In all cases, both groups were below normative groups.

With respect to psychological and emotional well-being, as reflected in behavioral indicators, the picture is equally disturbing. Bassuk and Rubin (1987) assessed behavioral profiles using the Simmons Behavior Checklist (a parent-report measure of behavioral disturbances) of a Massachusetts sample of 55 homeless 3-to-5-year-olds, and compared them with two other samples used for norming the checklist -- one "normal" and one labeled as emotionally disturbed. Sleep problems, shyness, and aggression were reported more frequently by mothers of children who were homeless than by mothers of the emotionally disturbed sample. These behaviors, along with attention deficits, speech delays, withdrawal, dependency, poor coordination, and toilet-training problems were more frequently mentioned for the homeless children than for the children in the normal sample. However, when their scores were compared to a Boston sample of low-income housed preschoolers, no meaningful differences were found; both groups had scores that were worse than the scores of both norming groups (Bassuk & Rosenberg, 1990). This raises concerns about the poor housed children as well.

Using the Child Behavior Checklist (CBCL), a measure which was also used in the NYFSP study, Rescorla et al. (in press) found that, compared to low-income housed preschoolers, homeless preschoolers were reported to have higher than expected rates of behavioral problems -- similar to those above -- at levels indicating a need for psychiatric referral. Wood et al. (1990), using a modified version of the CBCL, reported similar findings.

These data are reinforced by observational studies and teacher accounts of homeless preschoolers enrolled in early childhood education programs in New York City (Molnar, 1988; Phillips & Hartigan, 1984), which reported the following types of behaviors: short attention span, withdrawal, aggression, speech delays, sleep disorders, difficulty in organizing behavior (especially during transitions), "regressive"/toddler-like behaviors, inappropriate social interaction with adults, immature peer interaction (e.g., lack of empathy and inability to share), and immature motor behavior. However, observers also noted the surprising toughness and adaptability, including notably strong sibling relationships, that some homeless children exhibited.

Research on rates of behavioral and emotional functioning among school-aged homeless children has documented that they exhibit higher than expected rates of clinical anxiety and depression (Bassuk & Rosenberg, 1988, 1990; Masten, 1990; Rescorla et al., in press; Wagner & Menke, 1990; Wood, 1990). However, comparisons with local samples of housed, same-aged peers have not uniformly found differences. In other words, low-income groups -- irrespective of housing status -- are at significant risk.

Early Childhood Education. There is a considerable body of evidence attesting to the ameliorative power of early childhood education in the lives of young economically-disadvantaged children (e.g., Bronfenbrenner, 1974; Consortium for Longitudinal Studies, 1983). A high quality early childhood experience not only can have positive effects on a child's cognitive and socioemotional development in the short-term, but more fundamentally, it can produce substantial positive benefits on the long-term educational and general life experiences of poor children. In spite of this evidence, however, the impact of early childhood programs on the growth and functioning of young children who are homeless has not been systemically explored. This study by NYFSP fills this gap in part, but much remains to be done.

Family Functioning

Parent-Child Relationships. Children's developmental status cannot be considered separately from the context of the whole family. For example, the two New York City observational studies mentioned above (Molnar, 1988; Phillips & Hartigan, 1984), as well as a participant observation study conducted in an Atlanta night shelter (Boxill & Beaty, 1986) noted an unusual degree of ambivalence in mother-child relationships. The Atlanta researchers characterized them as a function of the "unraveling" of the parental role in a public shelter environment, as the adult role of provider, family head, organizer, and standard-setter is eroded by others.

Mental Health. The results of clinical interviews with 49 mothers living in eight family shelters in Boston indicated that 22% exhibited the presence of major psychiatric syndromes (e.g., major affective disorders, including depression, substance abuse, mental retardation, and schizophrenia, as classified according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [DSM-III]), compared to 6% of a comparison group of 81 low-income housed mothers (Bassuk & Rosenberg, 1988). Seventy-one percent of a Massachusetts sample of 80 homeless mothers, compared to 15-20% in the population at large, were diagnosed as having personality disorders (e.g., dependent, passive aggressive, antisocial) (Bassuk, Rubin, & Lauriat, 1986). Anecdotal evidence points to maternal depression as one of the more common side effects of homelessness (Molnar, 1988). This may prove important, especially for the young child, because research suggests that sustained parental depression has particularly negative consequences for children, more so than other forms of mental illness (e.g., Lyons-Ruth, Botein, & Grunebaum, 1984).

Social Supports. For many homeless families, by the time they request emergency shelter, all personal and family resources have been exhausted. For example, in New York City, 82% of families who seek emergency shelter have come from doubled-up situations, many having stayed with relatives or friends after losing their housing (Knickman, et al., 1989). Although families seeking shelter were more likely to report that they had either a mother or grandmother living, another close relative, or a friend than did housed public assistance families, they were less able to draw on their networks for housing assistance. Bassuk and her colleagues (Bassuk & Rubin, 1987; Bassuk, Rubin, & Lauriat, 1986) have also compared the social support networks of homeless and housed families. When Boston women were asked to whom they could turn in times of stress, those who were housed reported more supports than women who were living in family shelters. Seventy-four percent of the housed women, compared to only 26% of the homeless women could name up to three potential supports. Two percent of the housed women, compared to 22% of the homeless women, could name no one. McChesney (1986) also found that homeless women often lack social ties. However, Shinn, Knickman, & Weitzman (1989) found no differences in the number of social ties reported by a group of homeless mothers requesting emergency shelter in New York City and a randomly selected sample of mothers on public assistance. Neither did Goodman (in press), who examined the social networks of 50 homeless and 50 low-income housed mothers in Boston. She found no differences in terms of: the size and composition of their social networks, the nature of the support they received, and the degree of contact they had with parents and other family members. Only when it came to evaluating the level of trust they experienced in their relationships were there differences, with homeless mothers indicating a lower level of trust than the mothers who were housed.

Service Linkages

Too often, programs for vulnerable and at-risk families can be characterized by two key features: (1) the separation of services to adults and children, and (2) the lack of coordination of all services. Like much of the existing research, services address the needs of the child and other family members in a piecemeal fashion. Yet, research tells us that for early intervention to have a lasting effect on young children's growth and development, a comprehensive, integrated family-based approach is critical (see Cicchetti & Toth, 1987).

In the case of homeless families, the gaps in our knowledge base are considerable. The Massachusetts study which is cited above is the only one to date that has included a focus on service utilization. Homeless families reported less involvement with a housing or human service agency than low-income housed families (50% vs. 75%, respectively). For example, homeless mothers were less likely than their domiciled counterparts to to be receiving housing subsidies (28% vs. 61%). In addition, similar to findings summarized above in the health section, homeless mothers were less likely than housed to be receiving food stamps (55% vs. 83%), or WIC supplements (33% vs. 54%) (Bassuk & Rosenberg, 1988). At present, data that address family service needs as a whole -- and not just as discrete non-interacting domains -- are almost nonexistent. They are primarily anecdotal. A systematic profile of child development and family functioning linked to service usage has been a critical missing piece in trying to understand which strategies are most effective for supporting homeless and other extremely vulnerable families and their young children.

A major purpose of the present study was to assess child development within the context of the family unit as a whole, by examining the interrelationships of child and adult variables. In addition, by recruiting a comparison group as similar to sheltered families as possible, we sought to look specifically at the impact of homelessness on chronically poor families.

METHODOLOGY

SAMPLE

One hundred sixty families participated in this study: 84 were homeless and living in New York City shelters; 76 were housed and living in an apartment, theirs or someone else's.[1] The primary eligibility criteria for participation were: low-income status (e.g., Aid to Families with Dependent Children [AFDC] or Supplemental Security Income [SSI] as the source of the family's income), and having a preschool-aged child 3 through 5. In addition, since the influence of early childhood education (ECE) was of interest, children were grouped according to whether or not they had been enrolled in an ECE program for a minimum of 12 weeks.

This was not a random sample. Nonetheless, compared to other existing data sets, some of which are based on large random samples, we believe it is a reasonably representative sample of homeless and low-income housed families living in New York City (see the following chapter for a detailed description of the demographic characteristics of the participating families). Table 1 presents the distribution of the sample on those demographic characteristics that were of concern during recruitment. Both housed and homeless families were sampled so that the racial/ethnic distribution would approximate that for all homeless families in the New York City shelter system: two-thirds black, 30% Hispanic, and 4% other.[2] Children enrolled in ECE programs were intentionally oversampled, especially homeless children, for whom few ECE slots exist (less than 20% of the homeless preschool population citywide, HRA Agency for Child Development, 1990).

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[1] Many would argue that the 100,000 households who live doubled-up in apartments (Bach & Steinhagen, 1987) throughout New York City are also technically homeless. New York City Housing Authority (NYCHA) analyses of utility usage, garbage, and the like suggest that as many as 35,000 families may be living doubled-up in NYCHA buildings alone (Altman & Weinberg, 1989). However, in order that our data be comparable to other existing data, we defined homeless families only as those living in the emergency shelter system, thereby excluding doubled-up families, as well as an unknown number of families living on the streets or in abandoned buildings.

[2] This resulted in the oversampling of black families, and corresponding undersampling of Hispanic families, in the housed group. This was intentionally done for the purpose of controlling for the effects of race/ethnicity.

Table 1

Sample Characteristics: Housing Status, Race/Ethnicity, and Child's Enrollment in Early Childhood Education (ECE)

	ECE		No ECE		Total	
	N	%	N	%	N	%
Housed						
Black	25	58	20	61	45	59
Hispanic	16	37	10	30	26	34
Other	2	5	3	9	5	7
Totals	**43**	**57**	**33**	**43**	**76**	**100**
Homeless						
Black	37	70	22	71	59	70
Hispanic	14	26	9	29	23	27
Other	2	4	0	0	2	2
Totals	**53**	**63**	**31**	**37**	**84**	**100**
Total Sample						
Black	62	65	42	65	104	65
Hispanic	30	31	19	30	49	30
Other	4	4	3	5	7	5
Totals	**96**	**60**	**64**	**40**	**160**	**100**

$^{*}p < .05$
$^{**}p < .01$
$^{***}p < .001$

Sample Recruitment: Homeless Families

Three types of emergency shelter exist in New York City: Tier I and Tier II facilities, and hotels.[3]

(1) *Tier I.* Tier I shelters are congregate, barracks-type facilities lacking private rooms for families. New York State Department of Social Services (DSS) regulations (Part 900) limit a family's stay to 21 days. Thus, because of their intended short-stay nature,[4] we did not recruit from Tier I facilities.

(2) *Tier II.* Tier II shelters and family centers offer families private sleeping accommodations with private or shared bathroom facilities and congregate dining; others (Family Centers) are set up as small apartments, complete with kitchen facilities. State DSS regulations require that they provide services for housing preparation, recreation, information and referral, and child care. Fifty-nine families from three Tier II shelters participated in the study (see Appendix A for a list of the cooperating Tier II facilities). (We included in this category the one family who was living in a battered women's shelter.)

(3) *Hotels.* Commercial hotels provide a family with a room (or two, if the family is large enough), and either private or shared bathroom facilities. Regulations for hotels are essentially limited to sanitation and maintenance requirements. Hotels sheltering homeless families, which are known locally as "welfare hotels," were once the largest provider of shelter for families (in the late 1980s, they sheltered three-quarters of the city's 5,000+ homeless families). Varying greatly in size and conditions[5], the largest of the hotels gained notoriety because of their intolerable living conditions.

Altogether, 25 families from four hotels participated (see Appendix A). This was a shift from our original sampling plan. Initially, we expected to recruit our entire sample from among the hotel population. However, the City's plan to stop using welfare hotels to house homeless families by June 30, 1990 caused us to modify our sampling plan, and include families living in Tier II Shelters.

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[3] In response to federal Department of Health and Human Services plans to restrict states' use of AFDC and emergency assistance funds to meet emergency shelter needs, in the fall of 1988, the administration of former New York City Mayor Edward I. Koch established June 30, 1990 as a target date for ending the use of commercial hotels (locally known as "welfare hotels") for sheltering homeless families. Although his successor, Mayor David N. Dinkins, basically held to the same plan, recent months have seen increased use of hotels as the number of renovated City-owned apartments and new Tier II facilities have failed to keep up with demand.

[4] This is a limit not rigorously observed, according to a recent study conducted by the Citizens Committee for Children (1988).

[5] The two largest welfare hotels-- the Prince George Hotel and the Hotel Martinique -- each sheltered more than 400 families at a given time.

In total, 30% of the 84 homeless families in our sample were living in hotels at the time of their participation in the study, and 70% were living in Tier II shelters. Comparable citywide statistics in late May, 1989 (when NYFSP data collection was well underway), for the 4,200 families living in New York's emergency shelter system were: 54% in hotels, 34% in Tier II facilities, and 9% in Tier I shelters (HRA, 1989, May).[6] For all homeless families, only those who had been living in the shelter system for at least three months were eligible for participation in this study.

Recruitment strategies varied slightly from site to site and depended on whether or not we were recruiting families with children in ECE programs. The ECE group was recruited both by addressing organized parent support groups and by speaking with parents who were either dropping off or picking up their children. The non-ECE group was recruited primarily by knocking door-to-door in emergency shelters and at various food programs and health clinics.

Sample Recruitment: Housed Families

The low-income housed comparison group was recruited from a variety of sites on the Upper West Side of Manhattan. The ECE sample was recruited primarily through Head Start centers (see Appendix A). We concentrated our recruitment activities on Head Start programs rather than day care since federal regulations stipulate that at least 90% of Head Start's enrollment must be at or below the federal poverty line. Although a sizeable number of working families are poor enough to meet Head Start's income criteria, only AFDC families were eligible to participate in this study -- working families were not.

The non-ECE housed sample was the most difficult to recruit, since, when recruiting through an agency or organized program, there is a risk of encountering an atypically well-informed and well-served group of people. Therefore, to ensure as broadly representative a group as possible, we recruited from a mix of sites, including two food pantries, two health care facilities, and one tenant organization.

The use of multiple sites, however, created logistical complications. Since each site had its own procedures for granting access to outsiders like ourselves, the lead-in time from first contact with the program and first contact with a family was often lengthy, and added considerably to the entire sample recruitment process. Recruitment strategies varied as well -- from approaching mothers with children waiting in line at a food pantry, to a role-play enactment of the interview at a Head Start parents' meeting.

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[6] Fifteen months later, only 9% of homeless families were being sheltered in hotels, compared to 69% in Tier II facilities, 16% in Tier I shelters, and the remaining 6% in special facilities, such as battered women's shelters (HRA, 1990, August).

The refusal rate of eligible families was low.[7] Far more problematic was the ineligibility of interested families. Initially, a housed family was ineligible for participation if they had experienced an episode of homelessness sometime in the past. However, the incidence of prior homelessness among low-income housed families, especially families recruited at food pantries, was high enough that this criterion proved impractical since it eliminated too many potential participants. In response, the eligibility timeframe of a prior homeless episode was changed twice from "never" to "not in the past 5 years," to "not during the lifetime of the target child." Nonetheless, a few housed families with more recent episodes of homelessness were inadvertently included in the sample since we did not learn the full details of their recent housing histories until the interview itself.

MEASURES

As discussed earlier, the focus of this study was on the relationship between indices of child development, family functioning, service linkages, and the conditions of homelessness and chronic poverty. After reviewing the literature, we selected instruments according to the following criteria: strong psychometric properties (e.g., reliability and validity); availability in Spanish; sensitivity to constraints of the environment and to the limited concentration and attention span of young children, as well as the demands on a potentially overwhelmed parent; and freedom from class and race bias. Applying these criteria, five instruments were selected and two were developed especially for the study.

Child Development Indicators

Two aspects of child functioning were of prime interest: (1) the underlying capacity of the individual to deal effectively with the world, which is referred to here as "development;" and (2) the concrete, observable responses of the person, which is referred to as "behavior."

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[7] Ordinary computations of refusal rate do not seem to apply because of the conditions that accompanied recruitment. For example, in a food pantry or health clinic, not all "regulars" come on a particular day; nor is it possible to reach all that do. Very few people refused the study's person-to-person recruitment, but the precise figure is not firm.

"Development" is essentially a process, not a static condition. It represents the person's "evolving conception" of and relation to the environment, as well as his or her "growing capacity to discover, sustain, or alter its properties" (Bronfenbrenner, 1979, p. 9). It is the result of constant interaction with the physical and social environment. At the same time, however, it is stable -- though malleable.

Development is generally thought of in domains: *cognitive* (which includes memory, language, concept development), *physical* (including fine and gross muscle development, in addition to the more standard aspects of physical maturation contingent on proper nutrition), and *social* (including the evolution of a sense of self and one's relationship to other social beings; achievement of trust, autonomy, initiative [cf Erikson, 1950] are some of the aspects associated with social development). Non-physical development can only be inferred by observing children's activities and how they verbally and non-verbally interact with the world. Only the products, or outcomes, of the processes of development can be observed.

"Behavior," on the other hand, is by definition more concrete, more immediate, and more sensitive to the contingencies of the moment. While motivation must be inferred, behavior itself is directly observable.

We chose a developmental screen and a behavioral checklist to provide us with our respective profiles of child development and behavior.

(1) Early Screening Inventory

A developmental screen, rather than an in-depth battery, was chosen for reasons of practicality. It was of primary importance to minimize intrusiveness on the child and family. Developmental screens are short. On average they take 15 to 20 minutes to administer, compared to an hour or more for a full-scale developmental assessment. However, use of a screen brings with it certain limitations. The primary purpose of a screen is to identify whether there is a need for further evaluation. In other words, the results of a screen are only suggestive. If they indicate that a child may be at risk, further assessment is necessary in order to determine whether there is indeed a problem and, if so, of what particular nature. Moreover, conclusions cannot be drawn about performance in specific domains, *per se* (e.g., language, perception, gross-motor). Because screening instruments are designed to be short, they do not include enough items for reliable subscale analyses. It is the child's total score that is of interest.

The Early Screening Inventory (ESI) (Meisels & Wiske, 1988), a brief developmental screening instrument, was used to assess children's performance in speech, language, cognition, perception, and gross and fine motor coordination. Conclusions drawn from ESI results are based on the child's performance as well as information obtained from parents through use of the ESI Parent Questionnaire, which was also administered.

The ESI is an individually administered instrument. There are two versions: one for 3-year-olds (Meisels, Atreya, & Olson, 1988) and one for 4- to 6-year-olds (Meisels & Wiske, 1988). Items on the ESI were developed by the developers of the screen, or selected/adapted from well known diagnostic and screening instruments.[8] Both versions include measures of: Visual-Motor/Adaptive (including draw-a-person, copying of forms, visual sequential memory, and block building), Language and Cognition (number concept, verbal expression, and verbal reasoning), Auditory Sequential Memory, and Gross Motor/Body Awareness. Available in both English and Spanish versions, the ESI takes about 20 minutes to administer.

Pilot testing of the ESI. Two project staff conducted an initial phase of pilot testing with a sample of 20 children, ranging in age from 3 to 6 years, living in New York City welfare hotels (see Klein, Hartmann, & Molnar, 1989). This level of piloting confirmed that children understood and enjoyed doing the ESI tasks, that the administration time of 20 to 30 minutes did not exceed the limited concentration and attention span of children in this age group, and that the test could be successfully administered even in potentially distracting and busy environments (e.g., the corner of a day care center room).

(2) The Child Behavior Checklist

The constraints of time and the need to minimize intrusiveness prevented direct observation of child behavior. Thus, a behavior checklist was selected for each child's mother to complete. The Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1983; McConaughy & Achenbach, 1988) focuses on the occurrence of behaviors relevant to children's mental health referrals. The CBCL was chosen for several reasons. First, conditions of homelessness and chronic poverty do not support optimal child development. Thus, we wanted to document children's behavioral and emotional responses to the stressful conditions under which they are living. The CBCL is one of the most respected and widely used instruments for assessing behavioral and emotional problems. Second, although we were also interested in positive coping behaviors, considerably more emphasis has been placed on the construction of referral-linked assessments, perhaps because behavior problems are not only easier to document, but require immediate intervention, whereas competent behaviors by definition do not. Thus, we were faced with the immature state-of-the art of measuring adaptive/competent behaviors and could not find a suitable instrument. Finally, we wanted to compare our data with those of other researchers. Use of the CBCL made this possible since it has been widely used by others.

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[8] The ESI exhibits sound psychometric properties: Concurrent validity with the McCarthy Scales of Children's Abilities is .91; predictive validity with first grade performance is .82; test-retest reliability is .82; and inter-rater reliability is .91 (Meisels & Wiske, 1988).

Like the ESI, the CBCL has two versions and is available in both English and Spanish. One version of the CBCL (Achenbach & Edelbrock, 1983) covers ages 4 to 16 and includes a list of 113 behavioral problems. It provides separate norms for children ages 4 to 5, 6 to 11, and 12 to 16, by sex. Within each age group, separate scales have been developed using factor analytic techniques.[9] For 4- and 5-year-olds, there are ten specific scales: Social Withdrawal, Depressed, Somatic Complaints, Aggressive, Immature (boys only), Sex Problems, Schizoid, Delinquent (boys only), Obese (girls only), and Hyperactive (girls only). These are further grouped into two broad-band factors: Internalizing and Externalizing. A second version of the CBCL with 100 items covers ages 2 to 3 years (McConaughy & Achenbach, 1988). It, too, is grouped by Internalizing and Externalizing factors and has six scales: Social Withdrawal, Depressed, Sleep Problems, Somatic Problems, Aggressive, and Destructive.[10]

Mothers rate their child on each item according to whether it describes their child currently, or within the last several months (6 months if the child is from 4 to 16 years of age; 2 months if the child is 2 to 3 years of age). Items are rated on a 0-1-2 scale, corresponding to "not true," "somewhat or sometimes true," and "very or often true", respectively. The CBCL takes approximately 20 to 25 minutes to complete.[11]

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[9] For the 4- to 16-year-old version: 116 of the 118 behavior problem items have been found to be significantly associated with clinical status, indicating strong content validity. Concurrent validity of CBCL profile scales with corresponding scales from the Conners Parent Questionnaire and the Quay-Peterson Revised Behavior Problem Checklist ranges from .71 to .92 for clinically-referred 6- to 11-year-olds. Test-retest reliability of item scores has been established at .95 at 1-week intervals and .84 at 3-month intervals; inter-interviewer reliability is .96 (Achenbach & Edelbrock, 1983).

[10] As a check on discriminative validity, the scores of a referred group of 2-3-year-olds were compared with those of a nonreferred group. Referred children scored significantly higher on all scales than nonreferred children. Mean test-retest reliability of item scores has been calculated at .87 at 1-week intervals, and .69 at 1-year intervals. (cf Achenbach, Edelbrock, & Howell, 1987)

(3) Child Health Data

As discussed in the introduction, good health is a prerequisite to the optimal development of young children. General child health data came from two sources: the ESI Parent Questionnaire which included questions about the child's medical history, including birth history, and current health status; and the Use of Services Questionnaire (see below) which included questions about the child's access to health care, and rate of occurrence of certain illnesses over the past year.

Family-Based Data

Child development cannot be considered in isolation from the total family system. We know, for instance, that poverty negatively affects child development. It has a direct effect insofar as the immediate physical environment compromises children's opportunities for optimal growth through inadequate nutrition, unhealthy/unsanitary living conditions, and a paucity of developmentally appropriate materials or activities. The literature reviewed earlier indicated that the environmental assaults on health and general development are even more severe in circumstances of homelessness.

But poverty also has an indirect effect on children through its impact on other family members and the ways in which they interact with the child. A growing body of literature (cf McLoyd, 1990) suggests that the inconsistent and overly punitive parental behaviors frequently characteristic of economically disadvantaged parents -- and which are known to have deleterious consequences for children's socioemotional functioning -- are mediated by the parents' psychological distress brought about by poverty and the cluster of chronic negative life conditions and events, and the erosion of supports that follows in its wake. To date, these have not been of major concern in research on homeless families. Thus, NYFSP's look at young children would have been incomplete without a focus on the family. Depression, recent life events, social supports, and service linkages were examined among NYFSP families, focusing especially on the mothers.

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[11] Depending on the mother's preference, the interviewer either read each item to her, or she completed it herself.

(1) Life Experiences

As an introduction to the family's particular situation, a general family background protocol was developed by Bank Street staff to solicit information on the following variables:

- Family variables, including family size, family structure, age of family members, level of education, employment experience, language use at home.
- Housing history, including length of time in New York City, reasons for current episode of homelessness (if homeless) or most recent episode (as applicable for housed families), re-housing plans, as well as a detailed account of all housing arrangements over the past two years.

These data enabled us to understand our single contact with families within a more long-term context, as well as to examine the representativeness of the sample in relation to other New York City data bases.

(2) Maternal Depression

Depression is more common among women than among men, among the young than the old, among those with lower than higher levels of education, and among those with low income (Sayetta & Johnson, 1980); in particular, single women with young children (Guttentag, Salasin, & Belle, 1980; Pearlin & Johnson, 1977). As noted earlier, depression is one of the most commonly observed effects of homelessness on mothers. This has obvious implications for child development. Young children, in particular, may be especially vulnerable to the negative consequences of their mothers' depression, because parental depression, with its attendant psychological unavailability, appears to be more disruptive at the stage of development when children normally use their secure relationship to the parent as a base from which to explore the environment (Cicchetti & Aber, 1986).

Maternal depression was assessed using a screening instrument developed by the National Institute for Mental Health's Center for Epidemiologic Studies to measure current level of depressive symptomatology in the general population. The Center for Epidemiologic Studies Depression (CES-D) Scale (Radloff, 1977) is a 20-item, Likert-type self-report symptoms checklist that is available in English and Spanish. The items represent the major components of depressive symptoms identified in the clinical literature: depressed mood, feelings of guilt and worthlessness, helplessness and hopelessness, lessened activity, and appetite and sleep disturbances. Items are rated on a 0-1-2-3 scale, corresponding to their frequency of occurrence during the past week ("rarely or none of the time" to "most or all of the time"). Although the CES-D is not a diagnostic tool, the cut-off score of 16 differentiates well between psychiatric inpatient and general populations.[12]

The CES-D has been used in early intervention studies of multi-risk, low-income urban populations, and self-reported maternal depression was found to be an important risk indicator for lowered infant mental development scores and for increased incidence of anxious infant attachment (Lyons-Ruth, et al., 1990). Such studies concluded that the CES-D scale provides an important screening instrument for identifying the segment of low-income mothers and infants at greatest social risk.

(3) Social Networks

The nature of a family's social support network is predictive of family stability and functioning and thus was an important focus of a study such as this one. Because the members of one's social networks can be sources of stress as well as support, depending on the level of demands and expectations that may be placed on an individual by these significant others, the nature of specific roles and their perceived support by the respondent was probed.

The *Norbeck Social Support Questionnaire* (NSSQ) was selected to examine the composition and characteristics of families' social networks. The NSSQ (Norbeck et al., 1981) is a self-report questionnaire designed to measure multiple dimensions of social support including both functional and network properties. Questions provide information about instrumental and emotional support, as well as frequency of contact and duration of the specified relationships, and recent losses of important supports. NYFSP Project staff translated the English NSSQ into Spanish.

In filling out the NSSQ, respondents are first asked to list all persons in their life that provide personal support and to specify the nature of each relationship i.e., counselor/caseworker, doctor, friend, sister, clergy, etc. Then, respondents answer a series of 11 questions pertaining to functional aspects of support, and rate each of their network members on a 5-point Likert-type scale. Additionally, questions provide information about frequency of contact, duration of the relationship, and recent losses of important supports. Administration time is approximately 15 minutes and the questionnaire format is especially designed to simplify this complex task for respondents. Three main variables can be generated from the NSSQ -- Total Functional, Total Network, and Total Loss -- as well as specific profiles about the nature of support provided by each network member identified by the respondent.

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[12] The CES-D has been well-validated in large-scale epidemiologic as well as clinical studies, with 99% of patients with known depression scoring above 16 (Weissman, Sholomkas, Pottenger, et al., 1977). The cut-off score of 16 also differentiates well in unselected community groups between depressed and non-depressed people with a false positive rate of 6.1% and a false negative rate of 35.4%. In addition to exhibiting good psychometric properties, the CES-D correlates with other depression scales such as the Zung Scale and Beck Depression Inventory at .90 and .81 levels, respectively, and with Research Diagnostic Criteria classifications of clinical depression from information collected on the Schedule for Affective Disorders and Schizophrenia (SADS) (Myers & Weissman, 1980).

(4) Life Events

Major life events (both good and bad) create stresses that have the potential to wear down a person's adaptive coping capacities. Poor families, in particular, experience multiple life stressors, among which homelessness ranks high in the stress and chaos it produces. We sought to examine the nature of the positive as well as negative events experienced by homeless and low-income housed families. Of particular interest was whether or not homelessness predictably clustered with other major life events.

The *Life Events Questionnaire* (Norbeck, 1984) asks respondents to go through a list of 70 items and identify those major life events they have experienced during the past year. Respondents are then asked to give a qualitative rating of the "goodness" or "badness" for each event selected and to assess the overall effect of that event, using a 4-point Likert- type scale (where 0 = no effect, and 3 = great effect). Items cover nine domains including health, work, school, residence, relationships, parenting, finances, crime, and legal matters. The Norbeck Life Events Questionnaire was selected because it yields both quantitative and qualitative information about life events. The instrument is essentially value-free, in that the respondent determines the salience and value (positive or negative) of the events. It has also been used in several studies of low-income families in urban areas. NYFSP Project staff produced a Spanish translation.

(5) Service Linkages

A major question is the extent to which service relationships outside the home can act as protective factors against the distress experienced by at-risk parents and children.

A Use of Services Questionnaire was developed by Bank Street College to assess a family's knowledge and perceived need of, as well as access to, a broad range of services in a number of key domains. They included: health (including prenatal care, drug/alcohol treatment, general child and adult health status), nutrition (including access to WIC, food pantries, soup kitchens), education (including infant stimulation, day care, after-school programs, parent education, job training), social services (including child abuse and neglect), housing, and welfare entitlements. Two slightly different versions were developed for housed and homeless families.

PROCEDURES

Data collection took place from April through November, 1989. Most typically, it consisted of an interview session with the mother, during which she responded to the seven instruments described above, while the child was separately administered the ESI. (In situations in which the child was screened at the ECE program, the mother was interviewed independently.)

Data collection was accomplished by a two-member team -- one to interview the mother[13] and one to screen the child (and after completion of the screen, to supervise the child until the mother had finished the interview). In combination, each team of two brought with it: experience with young children (all 7 child screeners had experience working directly with young children; 4 of them had previously worked in a day care program for homeless preschoolers), research experience, and the appropriate ethnic and/or language match.[14] In total, 14 racially and ethnically mixed staff (most of whom were blind to the specific objectives of the study) were involved in aspects of data collection.

Field staff participated in 16 and-a-half hours of training prior to the start of data collection. The five formal training sessions (supplemented by informal individually-based training) focused primarily on the data collection protocol, especially how to administer the standardized instruments. In addition, staff were instructed to be aware of possible child abuse and/or neglect and to immediately report any suspected incidences to the Project Director who would comply with New York State mandated reporting procedures. (No incidences were suspected or reported.)

Interviews averaged two and-a-half hours in length. Debriefing questions asked of the mothers at the conclusion of the session indicated that the majority of them welcomed an interested ear and found the interview to be a personally worthwhile experience.

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[13] Only mothers were interviewed for this study, although the mother's husband or partner was present during several of the interviews. Families in which the child's father or other relative had primary custody of the child were not eligible for participation.

[14] During sample recruitment, Hispanic mothers were asked to specify their language of preference for both themselves and their child.

Place

Interviews were conducted at a place and time that were convenient to the mother. Sites included: the program location at which the family was recruited; the family's apartment (if housed), the family's shelter room or other meeting space in the hotel or Tier II shelter (if homeless), and Bank Street College.

Interviews conducted in hotel rooms were the most difficult. The not atypical conditions are described by an interviewer:

> The temperature inside the room must have been 110° (it was 92° outside). There was no fan, no air-conditioner, so the place was like a sauna. Three full-sized beds pushed side-by-side took up most of the room. One folding table, one chair, a milk carton, a chest of drawers, and a wooden box were the only other furnishings. There was a separate bathroom, and a refrigerator, stove, and sink stood against one wall opposite the row of beds. Roaches were crawling on the floor and on appliances. The three-year-old target child was in the room throughout the interview. An obviously bright and alert child, he was well-behaved, but it was difficult for him not to interrupt the interview repeatedly. Both his mother and I sat on edges of the beds where, undoubtedly, he was used to playing during the day -- there was simply not much room elsewhere.

For us, these were inconveniences necessarily associated with the data collection process. But we were aware that, for the families we interviewed, it was their lives.

No-Show-Rate

Of 244 scheduled interviews, 80 (33%) were no shows. Families were rescheduled up to three times before being dropped from the sample. Twenty-nine families could not be successfully scheduled for an interview: 8 were dropped after three missed appointments; 21 moved from their shelter or apartment, or could not otherwise be located for rescheduling, even before three attempts were made.

Incentives

Each family was given $15 to compensate them for their time (plus carfare, if they traveled to Bank Street), and the target child (as well as all siblings under age 5) given a book or toy.[15] The family also received a resource guide to community-based services. Two guides were developed: one was a citywide guide for homeless families; the other was targeted specifically to low-income housed families living on the upper west side of Manhattan.

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[15] Books and toys were all solicited donations to the New York Family Services Project.

Informed Consent

Prior to the start of the interview, interviewers summarized what the interview session would involve for the mothers, and what the screening would be like for their children. Participants were then asked to sign a consent form (available in English and Spanish), which included a written guarantee of complete confidentiality. They kept a copy of the signed form for themselves.

Administration

As we did not want to embarrass respondents who may have lacked the literacy skills necessary to complete the self-report measures, we began the administration of each instrument by reading the items aloud. Women who preferred to read on their own generally interrupted or otherwise indicated their preference. It was obvious, however, that regardless of reading level, some women preferred the social exchange that occurred when the interviewer read aloud.

Feedback

Within a week of the interview, families were sent a thank you letter from the interviewer and a feedback letter from the child screener. The feedback letter was global in nature and included activities mothers might do with their children in order to help them develop some of the skills tapped by the ESI.

DEMOGRAPHIC PROFILE OF HOUSED AND HOMELESS FAMILIES

> "People have misconceptions about the homeless. They think they're poor, not just financially, but in character....People make assumptions about you when they see you walking out of a place like this. They think you're on drugs or irresponsible. These things aren't always true." (Martha Lonegan[1], a resident of a Tier II shelter)

The families who participated in this study were largely single-parent, minority families drawn from the ranks of the chronically poor. Tables 2 to 4 offer a detailed snapshot of the characteristics of both kinds of families involved in the study. Probably the most striking feature is just how similar the two groups were to each other. Although there were several significant[2] differences between them, for the most part, they were variations along the same continuum.

CHARACTERISTICS OF MOTHER

Age and Family Composition

As indicated in Table 2, mothers who were homeless were younger than their housed counterparts (27 vs. 29 years of age)[3]; 13% were 21 or younger, compared to 9% for the housed sample. The modal number of children for both groups was two, although families who were homeless had a higher mean number of children (3.25, range = 1-9 vs. 2.75, range = 1-6)[4]. This pattern was especially pronounced among blacks; 22% of homeless black families had five or more children. Three housed families and four homeless families indicated that, at the time of the interview, at least one of their children was in foster care.

Marital status is difficult to determine, given the welfare system's built-in disincentive for two-parent family units. Certain Tier II shelters also restrict

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[1] For reasons of confidentiality, all names have been changed.

[2] When the word "significant" is used in the context of reporting data, it is used in the statistical sense, meaning that differences between groups exist at a level exceeding chance occurrence. A generally accepted probability (p) level for concluding that an outcome did not occur by chance is one that is equal to or less than .05 (5%). This approach assumes a random sample – which ours is not. Even while we assume a fairly *representative* sample, the use of inferential statistics to describe differences between and within non-random groups leads to conclusions that are at best suggestive, although we think no less useful for identifying areas for future research and/or potential programmatic intervention.

[3] $t(158) = 2.48, p < .05$.

[4] $t(158) = 2.18, p < .05$.

Table 2

Demographic Profile of Mothers
Selected Variables

Variable	Homeless (N=84)	Housed (N=76)
Age	27	29*
Number of children	3.2	2.7*
Steady relationship with male	24 (29%)	23 (30%)
Living with target child's father	12 (14%)	17 (22%)
Race/Ethnicity		
Black (not Hispanic)	59 (70%)	45 (59%)
Hispanic	23 (27%)	26 (34%)
Other (white, not Hispanic; Native American; Asian)	2 (3%)	4 (7%)
Lifelong NYC residents	54 (64%)	36 (47%)*
Mean number of housing changes while growing up	3.6	2.2**
Family on public assistance (P.A.) at some time while growing up	57 (69%)	35 (46%)**
On P.A. for majority of childhood	38 (47%)	15 (20%)****
High school or GED diploma	31 (37%)	42 (55%)*
At least one work experience	66 (79%)	69 (91%)*

*$p < .05$
**$p < .01$
****$p < .001$

families to women and children only. Thus, questions about marital status were probably among the most sensitive ones that were asked, and the validity of the responses among the most problematic. About 30% of both groups reported that they were currently married or had a steady partner, of which 22% of the housed women and 14% of the homeless women were living with the target child's father.

Ethnicity

The racial/ethnic distribution of families (see Table 2) was predetermined to correspond to that of the New York City shelter system as a whole. This was done in order to hold the variable of race/ethnicity constant, since the sample was too small to include it as a major factor. However, this had the effect among the housed families of overrepresenting blacks and underrepresenting Hispanics, compared to the citywide population of families on public assistance.

Early Lives

Two-thirds of the mothers in the sample (70% of those who were homeless and 63% of those who were housed) had grown up in New York City. For some, there had been intervening moves to other places, but almost two-thirds (64%) of the homeless families and almost half of the housed families (47%) were lifelong New York City residents (see Table 2). Whether within New York City, or outside of it, while they were "growing up," women who were now homeless had moved an average of 3.6 times (range = 0 to 17); 29% had moved 5 or more times; 6%, 10 or more times. This is compared to non-housed women, who had moved an average of 2.2 times (range = 0 to 10) while growing up; 13% had moved 5 or more times. Although the means seem similar, women who were now homeless had experienced significantly more mobility while growing up than women who were housed, especially Hispanics.[5]

Childhood History on Welfare

All families who participated in this study were currently on welfare (Public Assistance [PA] or Supplemental Security Income [SSI]). When asked if their families had been on welfare while they were growing up (see Table 2), women who were now homeless were significantly more likely to say yes than those who were housed (69% vs. 46%, respectively).[6] Whereas both groups reported that their families of origin had experienced short-term crises (7% overall), or "on and off" periods of welfare dependency (3% overall), women who were currently without a place to live were significantly more likely to report being on welfare the majority of their childhood than women who had homes (47% vs. 20%, respectively).[7]

Educational Achievement

Overall, not even half of the total sample had graduated from high school or had received a general educational development (GED) diploma. At the higher end of the continuum, 18% of the housed women and 13% of those who were homeless had at least some college, technical, or professional school education. Notwithstanding the exceptions, this overall profile of low educational achievement was significantly more pronounced among the homeless than housed participants in this study. As shown in Table 2, only 37% of the mothers who were homeless had a high school or GED diploma, as compared to 55% of the housed mothers.[8]

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[5] $t(157) = 3.30, p < .001$.

[6] $X^2(2, N = 159) = 10.60, p = .005$.

[7] $X^2(1, N = 154) = 12.63, p < .001$.

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Why did they leave school? The single most frequently given reason was pregnancy. Forty-two percent of the total sample left school because of pregnancy. Only 7% left because of poor grades, only 4% because they got a job, only 2% were suspended or expelled. There were other reasons as well (some had home responsibilities, some said they just didn't like school, etc.), but far and away, parenting responsibilities superseded education. Sadly, for those who left, regardless of reason, not even half were encouraged by someone (a parent, teacher, friend, etc.) to stay in school. Now, however, among those who left school, the vast majority (85%) said they are planning to continue their education and get a GED.

Work Experience

Although the majority of the sample had worked at some point in their lives, those who were homeless were significantly less likely to have ever worked (79% vs. 91%),[9] and of those who had worked, to have worked less -- when asked the length of their longest-held job, the average for now-homeless women was almost a year less than for housed women: 25 months (range = 1 month to 11 years), compared to 35 months (range = 1 month to 14 years). Not surprisingly, education and employment were found to be related. Everyone with some education past high school (college, technical school), and almost everyone with a high school or GED diploma had had at least one job.

Although the majority of respondents had worked; overall work experience was limited. Half of the total sample (including those who had never worked) did not even have a full year's worth of continuous experience at the same job. Describing their longest-held job, 24% had held clerical positions, 21% had a service job (hair, sales, food preparation, etc.), 11% had factory positions, 9% were in nursing or health, and the remainder were miscellaneous (day care, domestic work, etc.).

At the time of the interview, the only families with jobs (less than 5%) were working "under the table" since all families were on public assistance. However, almost everyone (95%) wanted a job, especially a job that "pays real money." The reasons why they weren't working were, given their circumstances, rather self-evident. When those who wanted a job were asked, "What are the things preventing you [from being employed]?," the main reasons given were: have young children (62%), need more education/training (54%), and need day care (47%).[10] Lack of adequate housing was, of course, also an issue. Fifty-three percent of the homeless group gave it as a reason for why they weren't working; but so did 15% of the housed families.

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[8] $X^2(1, N = 160) = 5.42, p < .025$.

[9] $X^2(1, N = 160) = 4.52, p < .05$.

Vulnerability to Homelessness

The three variables just discussed represent significant differences between housed and homeless families which may signal specific points of vulnerability to homelessness. Greater exposure to public assistance while growing up, lower educational status, and reduced work experience are all factors which reduce an individual's economic options and therefore might contribute to underlying patterns of recurring economic distress for homeless compared with housed families. Moreover, they may entail a limited repertoire of the kinds of behavioral responses that are required to effectively negotiate many legal systems, for example, housing court. Taken alone, these three variables are surprisingly poor predictors of homelessness (Knickman et al., 1989), but may assume critical proportions in conjunction with housing instability.

These three risk indicators did not cluster together as tightly as one might have expected. Within our sample of 160 families, 87 mothers (34 housed, 53 homeless) did not have a high school or GED diploma, 53 (15 housed, 38 homeless) reported that they had been on welfare for the majority of their childhoods, and 25 (7 housed, 18 homeless) indicated that they had no work experience. Only 10 of the women we interviewed (2 housed, 8 homeless) shared all three conditions. These 10 mothers were, on average, younger than the rest of the sample (average age 25 vs. 28, respectively), and had more children (3.4 vs. 3.0, respectively). Clearly, for those families -- whether housed or homeless -- the road to a stable, secure future can be expected to be a difficult one.

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[10] These percentages add to greater than 100% since respondents could give more than one reason for why they weren't working.

ECONOMIC STRESS

Because only families on public assistance were recruited for inclusion in this study,[11] the housed and homeless samples had, among other things, poverty in common. As indicated above, these families, for the most part, were not new to poverty. More than half of the total sample had experienced welfare dependency while themselves children. In terms of their current welfare history, families who were homeless indicated that they had been on welfare an average of 60 months; housed families reported a slightly higher mean of 68 months.[12] Seventy-seven percent of the total sample had been on public assistance two years or longer, 22% for 10 years or more.

Table 3 offers further insights into the shared plight of housed and homeless

Table 3

Benefits, Sources, and Adequacy of Income

Variable	Homeless (N=84)	Housed (N=76)
% currently on P.A. 2 years or longer	71%	86%*
% currently on P.A. 10 years or longer	26%	18%
Regular financial support from child's father	25%	43%*
Any support (even if irregular)	30%	54%***
Effective life of welfare check one week or less	55%	72%*
Benefits described as insufficient	77%	92%***
Resulting in food shortages	54%	58%
At least one welfare case closing	56%	51%

*p < .05
**p < .01
***p < .005
****p < .001

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[11] Three families were dependent on SSI.

[12] Homeless: S.D. = 55 months, range = less than 1 month to 20 years; Housed: S.D. = 49 months, range = less than 1 month to 28 years.

The answer to the question, "How long have you been on AFDC/public assistance?" is difficult to interpret. Some respondents included only the length of time they had had their own cases; others included time on public assistance as part of their mother's caseload. Thus, this figure probably underestimates the total amount of time the household heads in this study had been on welfare.

chronically poor families. Intriguingly, the housed families interviewed indicated they felt considerably more strapped by public assistance benefits than their homeless counterparts. The vast majority of both groups but almost all of the housed families described their benefits as insufficient.[13] Indeed, over half of the homeless families but almost three-quarters of those who were housed indicated that their welfare checks lasted only one week or less.[14] What did families do when they ran out of money? One mother told us her response is to "sit and hang tight and pray to God everyday." When that's insufficient, she borrows, and when she's desperate she sells her things.

In addition, over half of both groups had experienced at least one welfare case closing while on public assistance. More importantly, well over half of these families experienced multiple closings, a phenomenon which the New York City Human Resources Administration (HRA), the city agency responsible for administering public assistance and emergency shelter, has linked to increased risk of homelessness (HRA, 1986). The reality of this risk can be better appreciated when considering that the average length of a case closing was 11 weeks for housed families, well beyond the means of most poor families to absorb without severe crisis.

Finally, both groups, but especially the homeless families, experienced limited rates of child support,[15] which given the already precarious financial status of these families, may have been just enough to throw them off balance.

HOUSING HISTORY

Table 4 highlights the housing histories of both groups who participated in this study. The homeless families had been in the New York City shelter system an average of 12 months (S.D. = 10 months, range = 1 month to 5 years), during which time they stayed in an average of 2.5 shelters (S.D. = 2.2, range = 1 to 15). Regarding the length of time families had been homeless: approximately one-third of the homeless sample had been homeless for less than six months, another third between six months and one year, and the remaining third for a year or more; 12% had been homeless for at least two years. Black families were homeless for a

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[13] $X^2(2, N = 160) = 11.60, p < .005$.

[14] $X^2(1, N = 159) = 4.92, p < .05$.

[15] Regular support: $X^2(1, N = 160) = 6.05, p < .05$. Any support: $X^2(1, N = 160) = 9.63, p < .005$.

Table 4

Housing Status and History

Variable	Homeless (N=84)
Number of times moved/past two years	3.2
Living in doubled-up situation immediately prior to entering emergency shelter system	63%
Never had own home or apartment	20%
Average time in shelter system at point of interview	12 mos.
Report of at least one previous homeless episode	21%
Main reasons for entering emergency shelter system:	
- Eviction for non-payment of rent	11%
- Eviction by primary tenant	26%
- Fire	18%

Variable	Housed (N = 76)
Number of times moved/past two years	.41
Doubled-up at least once in the past 2 years	39%
Currently doubled-up	30%
Never had own house or apartment	17%
Report of at least one homeless episode	28%
Would move from current housing if possible	66%

significantly longer period of time than other families, averaging 13 months in the shelter system, as compared to 9 months for the remainder of the sample.[16] This is however, most likely due to the larger number of children among homeless black families. In the sample as a whole, number of children was significantly related to length of time homeless.[17] Quite simply, the more children a family has, the harder it is to find an apartment.

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[16] $t\,(71.12) = 2.20, p < .05$.

[17] $r = .32, p < .005$.

The precipitating event that drove families to seek refuge in the shelter system varied. However, as shown in Table 4, the three major reasons were housing specific: over half of the families became homeless because of an eviction from a doubled-up situation (26%), eviction due to non-payment of rent (11%), or as the aftermath to a fire (18%). An additional 7% were evicted for other reasons (building converted or condemned). The remainder of the families lost or left their homes for a variety of reasons, e.g., domestic violence, drug trafficking or other criminal activity, and so on.

Housing Instability

Housing instability seems to be a salient characteristic of both housed and homeless families from our sample (see Table 4). As expected, for the two-year period documented immediately prior to the interview, homeless families proved to be extremely mobile averaging 3.2 moves (S.D. = 2.8, range = 0 - 18), many of those moves having occurred during the period of homelessness. Although housed families averaged only .41 moves for the same two-year period, other variables show that lack of movement alone may not define a stable housing environment. The figures for doubled-up living situations (a term that refers to two or more families living in a space intended for one) are indicative. The housed families we interviewed reported high rates for both current and previous doubling-up: 30% were currently doubled up, and an additional 9% had been doubled up sometime in the past two years, but now were living in their own place.

Living doubled up is not a stable housing arrangement. Doubled-up families have been found to be at high risk of losing their housing. An HRA (1986) study found that doubling-up was the most powerful single predictor of a family's likeliness of becoming homeless. Prior doubling-up characterized the NYFSP homeless sample; 63% of the families we interviewed reported that they were living doubled-up immediately prior to entering the emergency shelter system.

Indeed, the reported rates of doubling up among the NYFSP housed sample may be low. The majority of our housed sample was recruited from New York City Housing Authority (NYCHA) buildings where, as noted earlier, the Housing Authority itself estimates that as many as 35,000 families living in NYCHA apartments are currently living doubled up. Although NYCHA has shown considerable wisdom and restraint recently in not moving to evict illegal tenants, this has not always been the case, and families may well have been wary to reveal their actual circumstances to our interviewers.

Other variables on Table 4 also contribute to an overall picture of relative housing instability for both housed and homeless groups. For example, nearly an equal number from both groups reported that they had never lived independently -- that is, they had never participated directly in the housing market by being a primary leaseholder. This, too, has been identified as a major predictor of potential homelessness (Knickman et al., 1989). Moreover, an alarming number (28%) of housed families indicated that they had experienced at least one episode of homelessness in the past. This speaks to the precarious nature of what is called "permanent" housing. The fact that 21% of currently homeless families had at least one other homeless episode in their past also indicates that moving out of the shelter system into an apartment unfortunately cannot be interpreted as a definitive sign that a family is "home free." Finally, in more qualitative terms, many of the housed families indicated a strong lack of stable grounding in their present situations. Two-thirds stated that, for a variety of reasons -- including repair and maintenance problems, overcrowding, fear of violence and crime, or simply pursuit of better overall conditions -- if they could, they would move from their current housing.

Based on these findings, it appears that for most of the families we interviewed -- regardless of nominal designations -- chronic poverty renders housing problematic in general and potentially devastating in times of economic crisis. Such conditions also raise serious questions, both practically and in terms of policy issues, about current definitions of homelessness. The phenomenon of doubling-up is particularly troublesome as it defies clear categorization. On one hand, while those living doubled-up clearly qualify as having a roof overhead, the conditions they live in -- often shockingly stressful in nature -- would hardly meet any reasonable definition of acceptable housing. In any case, the overall complexity of housing issues for those families who participated in our study is indicative of an array of conditions that tend to consolidate, rather than separate, housed and homeless families in the larger environment of chronic poverty.

CHILD OUTCOMES

This chapter presents findings on children's developmental and behavioral status as determined by a combination of direct child assessment and parental report.

CHILD OUTCOMES ON THE EARLY SCREENING INVENTORY

"A table is made of wood, a window of cold." This was the response 4-year-old Albert gave to an item on the Early Screening Inventory (ESI), the instrument we used to profile child development. Although incorrect,[1] Albert's statement was an interested and eager response, and in its own way, quite accurate in its reflection of actual experience. Perhaps, more than anything, it indicates that the developmental lags we observed (which are described in the following sections), do not capture the full picture. While optimal development is clearly in jeopardy, children's motivation and potential is very much in evidence.

The ESI assesses children's skills in the following areas: visual/motor skills, number and cognition, auditory sequential memory, verbal expression, verbal reasoning, and gross motor/body awareness. Activities involve children in copying shapes, building a tower and/or bridge with blocks, drawing a person, playing a visual memory game, counting, repeating back series of numbers, describing common objects (ball, button, block, car), completing verbal analogies, and hopping, skipping, and other general body movements.

A child's total score can range from 0 to 30. However, if a child refuses three or more items, an ESI score cannot be computed. The total ESI score is generally classified into one of three groups: "OK" (a child's total score is not more than 1 standard deviation [S.D.] below the mean for his/her age group), "Rescreen" (the total score is between 1 and 2 S.D.s below the age group mean), and "Refer" (the total score is more than 2 S.D.s below the age group mean). We added a fourth group: if a child refused three or more items, the ESI was classified as "Unscorable." Children who score in the "OK" range are presumed to be developing normally. Children who score in the "Rescreen" range have marginal ESI scores and should be rescreened in 8 to 10 weeks. Finally, children who score in the "Refer" category are in the bottom 2.5% of the distribution of scores for their age group, and should be referred for more thorough assessment (Meisels & Wiske, 1988).

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[1] The correct answer to this analogy is "...a window of *glass*."

To take account of maturation, cut-off scores are re-adjusted at six-month intervals: 3-0 to 3-5, 3-6 to 3-11, etc. Thus, a given raw score can have a different meaning depending on the age of the child. (See Appendix B for the full set of ESI cutoff scores.)[2]

The Impact of Housing Status

> Four-year-old Rosa, her mother, and her 2-year-old younger brother lived in a Tier II shelter. Rosa and her family had been homeless for 16 months, after having been forced out of their apartment following a suspicious fire. Rosa was enrolled in the on-site day care program. Throughout the ESI screening, Rosa smiled and laughed, and overall seemed quite comfortable. She struggled hard on the block-building task. "One block right here and this like that...like this...Now I'm going to make a building." After several concentrated attempts, she had to give up, but her persistence stood out. She expressed herself confidently, even when incorrect. Asked to count what were 10 blocks, she went all the way up to 28. "It's green!" she said about the blue button. She also had some trouble with copying forms, auditory memory, and number concepts. But, her gross-motor behavior was smooth and easy, and she spoke in clear, complete sentences. Rosa scored 18, which for her age (4 years, 9 months), was in the "OK" range.

One of the hypotheses implicit in this study was that housing status (whether housed or homeless) would have an observable impact on the developmental status of preschool-aged children. However, this was not borne out by the data. Whether specific to each age range (see Appendix C), or collapsed across age groups as in Table 5, the mean ESI scores for the housed and homeless groups did not differ substantially from each other. The same pattern prevailed for the distribution of scores by classification group ("OK," "Rescreen," "Refer," or "Unscorable"). Even though a higher percentage of housed children scored in the "OK" range than

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[2] A note on sample size: ESI data were available for 151 children. Of the full sample of 160 families, 5 children were ineligible for inclusion in this study (e.g., child in family day care or public school kindergarten) and 4 children could not be screened (child was sick, family moved between scheduling of parent interview and child screening). Included in this resulting sample of 151 children were 12 children with unscorable ESIs (3 or more refusals). Total scores could not be calculated for those children, resulting in *two sample sizes for ESI outcome data*: N = 139 (63 housed, 76 homeless) for analyses using total ESI score as the outcome variable; N = 151 (70 housed, 81 homeless) for analyses focusing on the classification category (including unscorables) of raw scores. (See Appendix D for a tabular breakdown of the child sample.)

Table 5

Outcomes on the Early Screening Inventory (ESI)
Selected Mean Scores Collapsed Across Age Groups

	N	Mean Total Score (Range: 0 - 30)	S.D.
Housing Status			
Housed	63	17.7	5.0
Homeless	76	17.6	5.9
Exposure to ECE			
ECE	85	18.6*	5.4
No ECE	54	16.2	5.5
Sex			
Girls	72	18.5	5.7
Boys	67	16.8	5.2

Note: Of the original sample of 160 families (76 housed, 84 homeless), 9 children were ineligible for screening (i.e., child in family day care or public school kindergarten) or were not screened (child sick, family moved between parent interview and child screening); and 12 children had unscorable ESIs (3 or more refusals). This resulted in a sample of 139 for analyses using total score as the outcome variable.

* $p < .05$

Table 6

Child Outcomes on the Early Screening Inventory (ESI)
Classification Category by Housing Status

	Housed (N = 70)		Homeless (N = 81)		Total (N = 151)	
Classification Category	N	%	N	%	N	%
OK	36	51	37	46	73	48
Rescreen	14	20	26	32	40	26
Refer	13	19	13	16	26	17
Unscorable	7	10	5	6	12	8

homeless children living in hotels or Tier II shelters (51% vs. 46%, respectively, as shown in Table 6), this difference is not statistically meaningful.

Comparison to Norming groups. Both groups however, did equally poorly when compared to norming groups. Two different data sources were drawn upon for this purpose. Mean scores are from the original ESI standardization study (Meisels, Wiske, & Tivnan, 1984) involving white 4- and 5-year-olds from a predominantly working- and lower-middle class urban community. However, for classifying children's scores, we used as yet unpublished data from an ongoing national standardization study, including both English and Spanish samples, stratified by age, race, sex, education of head of household, and urbanicity (see Meisels, n.d.).

As shown in Table 7, except for the oldest age group, mean scores for the NYFSP 4- and 5-year-olds were almost a full standard deviation below the original

Table 7

Comparisons of NYFSP Scores to those from the ESI Standardization Sample 4- to 6-Year-Olds Only

A. MEAN SCORES

	Standardization Sample[a] (N = 452)			NYFSP[b] (N = 91)		
Age Range	**N**	**Mean**	**S.D.**	**N**	**Mean**	**S.D.**
4-0 to 4-5	50	21.3	5.4	31	16.9	4.9
4-6 to 4-11	227	23.2	5.3	34	18.4	4.8
5-0 to 5-5	175	25.9	5.4	22	21.0	5.1
5-6 to 5-11	[c]	27.2	5.4	4	25.8	3.9

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[a] See Meisels, Wiske & Tivnan (1984) for description of sample.

[b] Unscorable ESIs (N=5) are not included in the calculation of mean scores.

[c] Cutoff scores for the 5-6- to 5-11-year-old group were extrapolated from the standardization scores for subjects aged 4-0 to 4-5, 4-6 to 4-11, and 5-0 to 5-5. Standardization scores for 3-year-olds were not available. (Unpublished data, University of Michigan, Center for Human Growth and Development.)

Table 7 (cont'd.)

B. DISTRIBUTION OF SCORES

ESI Cut-Off Score	Standardization Sample[a] (N=960)	NYFSP (N=96)
OK	80 - 85%	53%
Rescreen	10 - 15%	31%
Refer	5%	11%
Unscorable	b	5%

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[a] See Meisels (n.d.) for description of sample. Data are unpublished (University of Michigan, Center for Human Growth and Development).

[b] Negligible.

ESI standardization group. In other words, if the distributions were superimposed on each other, the NYFSP mean scores would be at about the 20th percentile of the distribution curve of the standardization group's means.[3] Looking at the data another way and examining the distribution of cut-off scores ("OK," "Rescreen," "Refer," "Unscorable"), presents a similar picture. As shown in the bottom section of Table 7, almost 30% fewer NYFSP children -- regardless of whether housed or homeless -- were classified as "OK" than in the national standardization sample. Proportionately, more than twice as many were classified in both the "Rescreen" and "Refer" categories.

Interpretation of the Lower NYFSP Scores. What does this mean? The ESI is intended to "survey a child's ability to acquire skills, rather than the child's current level of skill achievement and performance"; poor performance thus suggests "not merely a lack of general knowledge, but the possibility of a delay or disorder in the child's potential for acquiring knowledge" (Meisels & Wiske, 1988, pp. 1-2). Thus, the distribution of scores for the NYFSP sample should be of great concern.

To better understand why this is so, the context of development must be considered. Environments devoid of many of the materials and experiences often taken for granted in more advantaged circumstances cannot help but make the disentangling of capacity from performance especially problematic. Even for an instrument as achievement-neutral as the ESI, prior exposure to the kinds of materials and tasks included in the instrument is obviously important to optimal performance. For example, children who have trouble holding and manipulating a pencil, because pencils or crayons are not common objects in their environments, may be more likely to have trouble with the two paper-and-pencil tasks (Draw A Person and Copy Forms) than a child with everyday exposure to things like pencils, and for whom the tasks may be more accurate reflections of underlying capacity.

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[3] Sixty-eight percent of the area under the curve of a normal distribution is within 1 S.D. either side of the group mean.

Nonetheless, while it is important to disentangle capacity/exposure issues, the bottom line is that children in poverty -- with and without homes -- appear to be at significant risk. However if, as it seems, the environment is a major contributor, the good news is that environments, with adequate resources and commitment, can be modified and re-directed in the support they offer children's growth.

The Impact of Family Background Variables

There were no differences in ESI performance -- either in the total score *per se*, or in its classification as "OK," "Rescreen," "Refer" or "Unscorable" -- that could be attributed to child sex, race/ethnicity, or the mother's educational level, work history, or age. In part, this may be due to insufficient within-group or between-group variance. That is to say, the sample was more homogeneous than less, and the total sample size too small for analyses to be sensitive to relatively subtle variations.

The Impact of Early Childhood Education

Evidence that exposure to a more age-appropriate setting can have an impact on developmental child outcomes can be found in examination of the influence of early childhood education (ECE) on the ESI scores. Sixty percent of the total sample (both housed and homeless) were enrolled in an ECE program -- either publicly-funded day care or Head Start -- and had been for a minimum of 12 weeks.[4] "Early childhood education" is not used here merely as a convenient labeling term, but as a description of the category into which both day care and Head Start (along with preschool, prekindergarten, etc.) fall. Use of this term expresses the philosophy that good quality[5] early childhood education is the same whatever the auspice. The only difference is length of day.

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[4] Mean: 12.3 months, S.D. = 8.9, range = 3 months to 38 months.

[5] A "good quality" program meets standards established by the National Association for the Education of Young Children (Bredekamp, 1987).

Although not definitive, the data are strongly suggestive (see Table 5). Mean ESI scores, collapsed across age groups indicated a significant impact of exposure to ECE: mean scores for children enrolled in day care or Head Start were higher than for children who were not enrolled (means of 18.6 and 16.2, respectively).[6] However, because a given score does not mean the same thing at different age groups,[7] mean scores were also compared for each age group. While not statistically significant, as illustrated in Figure 1 (and detailed in tabular form in Appendix E), the differences in mean scores consistently favored children who were in an early childhood program. Examining the same data in terms of the classification of total scores confirms the ECE advantage. Both Table 8 and Figure 2 show that, collapsed across age groups, a higher percentage of ECE-enrolled children were classified in the "OK" range (53%) than non-ECE-enrolled children (41%).[8]

This is a key finding. There is clearly a need for expanded early childhood programming for young children. Our data not only show the need but they show the power of appropriate intervention. Even children with as little as three months of exposure to Head Start or publicly-funded day care exhibited more age-appropriate performance on developmental tasks than children who lacked such an opportunity.

The Impact of Housing Status and ECE Considered Together. There was an apparently stronger influence of ECE for children who were homeless -- but only among the 3-year-olds. In other words, for the youngest children (ages 3-0 to 3-11), the mean total score for the sheltered group was significantly lower than that for the housed group (17.0 vs. 14.1, respectively).[9] This seemed to be related to the pronounced difference ECE made for the homeless group. Those who were in day care had a mean ESI score of 16.2 (equal to the housed no-ECE group), whereas those who were not had a low mean score of 10.6. (ECE also made a difference for the housed children, but not such a dramatic one.)

Features of the Early Childhood Education Advantage. What is it about early childhood education that might make a difference in how children perform on the

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[6] $t(137) = 2.47, p < .05$.

[7] Because of maturation, holding everything else equal, compared to a younger child, an older child should do better, just by virtue of being older.

[8] $\chi^2(1, N = 151) = 2.28, p = .07$, one-tailed.

[9] $F(1, 44) = 6.08, p < .025$.

Figure 1

Mean ESI Scores by Age Group and Access to Early Childhood Education

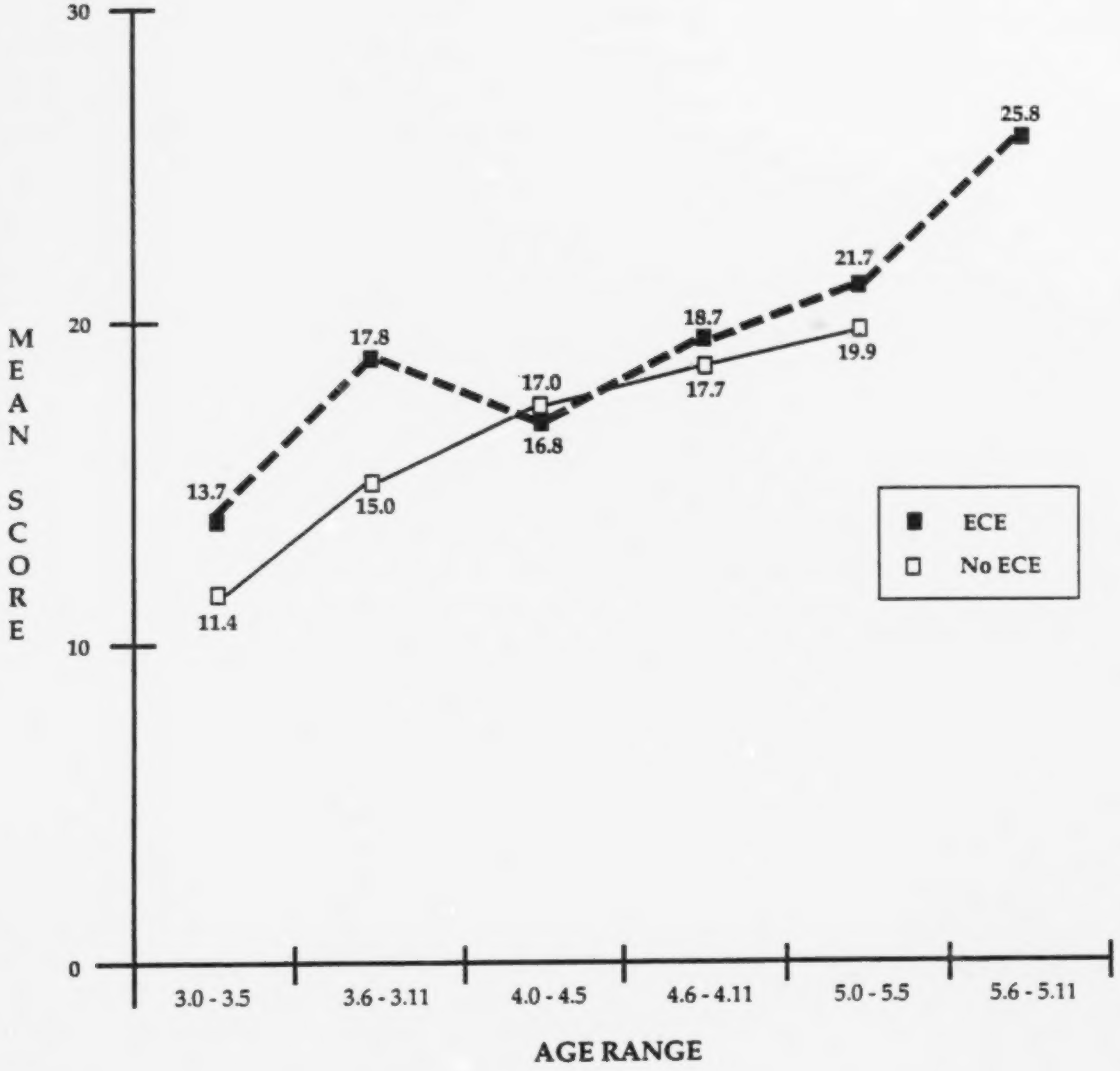


Table 8

Child Outcomes on the Early Screening Inventory (ESI) Classification Category by Exposure to Early Childhood Education (ECE)

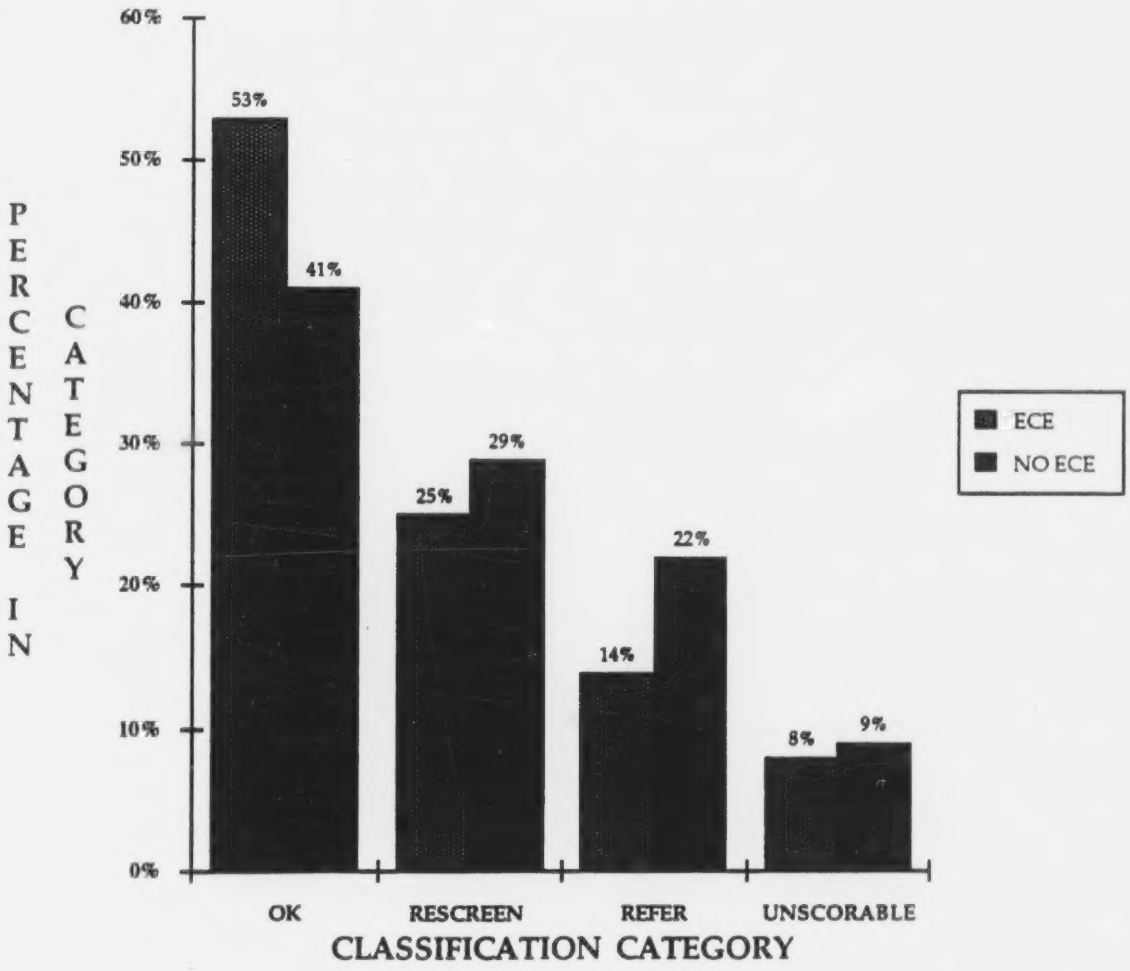
	ECE (N= 92)		No ECE (N=59)		Total (N = 151)	
Classification Category	N	%	N	%	N	%
OK	49	53	24	41	73	48
Rescreen	23	25	17	29	40	26
Refer	13	14	13	22	26	17
Unscorable	7	8	5	9	12	8

ESI? Well-designed early childhood classrooms provide for all areas of a child's development -- physical, emotional, social, and cognitive -- primarily through the creation of a physical and social environment that encourages children to learn through active exploration and interaction with adults, other children, and materials. The "stuff" of an early childhood program include puzzles; books; blocks; expressive materials like water, paint, and clay; props for dramatic play; activities, like cooking, that integrate math, science, and creative exploration with social exchange; opportunities for indoor and outdoor large-motor activity; and lots and lots of language, through songs, verse, story-telling, book-reading, and adult-child exchanges that build upon and extend children's budding communication skills.

Comparisons of the item-by-item performance of ECE-enrolled and non-ECE-enrolled children suggests ways in which the early childhood environment may support children's overall development, and by extension, their performance on the ESI. Among the 3-year-olds (3-0 to 3-11), for example, the ECE group performed better on verbal reasoning (sentence-completion items, such as, "Brother is a boy; sister is a *girl*.") -- a set of items clearly dependent upon the close connection between language and cognition. ECE-enrolled 3-year-olds also performed better on copying forms (horizontal line, vertical line, circle, cross). Not only does this task require experience with pencils/crayons and paper, but it also requires the ability to translate from the visual (seeing a shape) to the motor (drawing one like it). (Of course, each item also requires comprehension of what is being asked, and

Figure 2

Child Outcome on the Early Screening Inventory (ESI) Classification Category by Exposure to Early Childhood Education



compliance with the instructions.) Among the 4- and 5-year-olds (4-0 to 5-11), the ECE group did marginally, though consistently, better on the gross-motor items.

Notably, across age groups (3-0 to 5-11), the ECE children exhibited a stronger performance on the verbal expression section, in which children are asked to tell the examiner "all about" four separate objects: a ball, button, block, and small car. After the child's spontaneous comments, the examiner probes the child's knowledge of specific attributes of the objects ("What do we call it?" "What color is it?" "What shape is it?" [except for the car], and "What can you do with it?"). They also did better on the visual memory items. This task requires that the child memorize which picture card (out of 2 and then 3) is in which position (right, left, and center), and then correctly point to its location after the cards are turned face down. This is a test of short-term memory and the ability to follow rather complicated directions. Although the motivation to do well on the ESI tasks did not appear to differ between the ECE and non-ECE groups (in both groups, some gave up early while some put forth great effort), early childhood education fosters the improved ability to persevere and sustain attention despite distractions.

Probably most important, though, is the development of a trusting relationship with a dependable adult. Integral to the nuturance, support, and stability that such a critical relationship offers is the respect for the individuality and strengths of each child that is essential to the development of positive self esteem.

Mediating Variables. Given the above, shouldn't program enrollment have produced even stronger results? Early childhood education is not a univariate, dichotomous variable. An early childhood experience can vary along many dimensions. Probably because of their families' relatively more stable living environments, housed children were enrolled in an ECE program for a significantly longer period of time than children living in transitional shelter.[10] In addition, older children had been enrolled for significantly longer than younger children.[11] And, as one would expect, time in day care was positively related to ESI total score. The longer a child had been enrolled in an early childhood education program, the better the child did on the ESI.[12]

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[10] $t(94) = 2.27, p < .05$. Housed: $M = 15$ months, S.D. = 8.0, range = 4 - 30 months. Homeless: $M = 11$ months, S.D. = 9.3, range = 3 - 38 months

[11] $t(90) = 2.71, p < .01$. Older: $M = 14$ months, S.D. = 8.9, range: =3 - 38 months. Younger: $M = 9$ months, S.D. = 7.7, range = 3 - 36 months

[12] $r = .26, p < .025$.

But enrollment, alone, does not tell a complete story. Child attendance, program quality, and length of program day all have the potential to make a difference in the kind of impact the program has on a child (cf Phillips, 1987). In this study, ECE children were enrolled in a total of 20 classes in 6 centers. Although program quality was observed to vary,[13] the sample size was too small to allow for systematic examination of the impact of program quality on child performance. We did not collect attendance data, although we learned during the course of informal conversations with program staff that, for some children, it was a serious problem.

Finally, our sampling strategy had a built-in confound which complicates interpretation of the unexpected paucity of differences related to housing status. All but one of the housed children were recruited from Head Start programs (since recruitment of a suitable comparison group was focused on poor, non-working families), which were all half-day programs. In contrast, all of the programs from which we recruited children living in hotels or Tier II shelters were all-day programs. (This was the case regardless of whether they were on-site or off-site programs.) Thus, while homeless children had less ECE experience than housed children in terms of total time enrolled, they had more exposure to it while they were there.

Research is mixed on the benefits of all-day vs. half-day programs for young children. However, children who are experiencing the trauma and chaos of homelessness may need the structure, continuity, and stability of a longer day in order to feel secure enough to take advantage of what a program has to offer. Thus, while the extra components of a full-day program -- lunch, naptime, and increased opportunity for outdoor play -- are not necessarily considered program features whose impact would be reflected on the ESI, in fact, their indirect contribution may be significant. In the end, it is hard not to argue that all of the children in our study should have had access to early childhood education.

CHILD OUTCOMES ON THE CHILD BEHAVIOR CHECKLIST

"It has set him back...He keeps asking where home is." So went a mother's informal assessment of her child. Another said, "My daughter's personality has changed quite a bit. She's a lot more aggressive and she's picking up very bad habits." We were interested in those aspects of child behavior believed to be reflective of a child's overall emotional and/or psychological state. The Child Behavior Checklist (CBCL) was used to systematically tap the incidence of behavior problems, like those just mentioned, especially behaviors relevant to children's mental health referrals.

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[13] A subsample of classrooms were assessed using the *Early Childhood Environment Rating Scale* (Harms & Clifford, 1980).

Although we were initially concerned that the CBCL might be viewed as an overly negative instrument, mothers were very responsive to it. Many used it as an opportunity for talking in great detail about their children. In some instances, it even acted as an "icebreaker." This may be because of the everyday, nitty gritty nature of most of the items (e.g., wets the bed, bites fingernails, cries a lot), and the fact that the presence or absence of such behaviors contributes much to a family's day-to-day quality of life.

CBCL scores can range from 0 (if a parent circles 0 -- "not true" -- on every item) to 226 (if a parent circles 2 -- "very true/often true" -- on every item). Thus, the higher the score, the more problems a child is exhibiting. The mean problem score for nonreferred children in the general population is 41 for 3-year-olds and 25 for 4- and 5-year-olds.[14]

The Impact of Housing Status

Overall, the mean raw scores for the NYFSP sample were low (see Table 9). Among the 3-year-olds, total mean scores for the housed and homeless groups were virtually indistinguishable. Both had an average score of 33. Moreover, both groups scored even lower than a normative, non-clinical economically-stratified sample of 273 children living in the Worcester, MA area (see Achenbach, Edelbrock, & Howell, 1987 for descriptions of the clinical and non-clinical standardization samples). Achenbach and Edelbrock (1983) have indicated that very low scores can also be of concern, since all normally developing children exhibit some problem behavior. Thus, extremely low scores may be evidence of parental denial that problems exist, or lack of awareness of the child's day-to-day behaviors.

Regardless of housing status, the NYFSP 4- and 5-year-olds, on average, scored intermediately between an economically mixed, though predominantly white, normative sample of 200 children living in the Washington, D.C. area, none of whom had received mental health services in the past year; and a clinical sample drawn from an economically mixed, also predominantly white, sample of 200 children referred for outpatient mental health services at several dozen sites on the

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[14] The 2- to 3-year-old CBCL version has a different metric than the 4- to 16-year-old version.

Table 9

Comparison of NYFSP CBCL Raw Scores to those from the Standardization Sample

	Non-Clinical Normative Sample	**NYFSP** Housed	**NYFSP** Homeless	**Clinical** Sample
3-YEAR-OLDS[a]	(N=273)	(N=31)	(N=30)	(N=96)
Mean	40.6	33.3	33.1	70.5
S.D.	19.5	17.8	14.2	27.2
4- TO 6-YEAR-OLDS[b]				
BOYS	(N=100)	(N=22)	(N=27)	(N=100)
Mean	24.1	25.8	35.6	59.8
S.D.	14.2	11.8	22.0	30.1
GIRLS	(N=100)	(N=24)	(N=25)	(N=100)
Mean	25.2	37.5	33.8	58.8
S.D.	17.1	14.6	16.2	29.1

Note: One mother did not completely fill out the CBCL, for a total sample of 159.

[a] Source for the normative data: McConaughy & Achenbach (1988), p. 37.
[b] Source for the normative data: Achenbach & Edelbrock (1983), pp. 210, 213.

East Coast (see Achenbach & Edelbrock, 1983, for a complete description). The mean raw scores of the homeless sample (boys and girls combined) were significantly higher than those of the housed sample,[15] thus indicating a higher incidence of emotional problems, such as anxiety and depression, among children living in temporary housing.

Moreover, the range in incidence of reported behaviors were more extreme among children who were homeless than among low-income housed children. (This is indicated in Table 9 by the larger spread in the S.D.s for the 4- and 5-year-olds in the homeless sample -- especially boys -- which more closely resemble the clinical sample than either the NYFSP housed or normative non-clinical samples.)

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[15] $t(95) = 2.01, p < .05$.

Specifically, a significantly higher percentage of homeless 4- and 5-year-olds scored above the clinical cut-off than housed children of the same age (33% vs. 11%, respectively).[16] That is, 17 of the 52 4- and 5-year-olds who were homeless had total CBCL scores greater than 42, thereby putting them above the 90th percentile for the normative non-clinical sample. In other words, one-third of the homeless 4- and 5-year-olds exhibited behaviors of a serious enough nature and frequency to suggest the need for mental health intervention. Although this was far below the rate among a population of same-aged children already referred for mental health intervention, it was nevertheless three times the rate among the NYFSP housed sample as well as a non-clinical normative sample. Figure 3 graphically represents this relationship separately for girls and boys. To repeat, children who score above the clinical cut-off may need psychiatric referral. This is a finding that raises deep concerns about the conditions facing children living in temporary shelter. Among the NYFSP 3-year-olds, only two children (1 housed, 1 homeless) scored above the clinical cut-off. Thus, they will not be discussed further.

CBCL Factors. The ten scales of the CBCL (six for the 2- to 3-year-old version) are grouped into two broad-band factors -- Internalizing and Externalizing -- which correspond to the widely identified distinction between fearful, inhibited, and over-controlled behaviors (Internalizing) on the one end of the behavioral continuum, and aggressive, antisocial, and undercontrolled behaviors (Externalizing) on the other. As a whole, children who were homeless were more likely to be above the clinical cut-offs for both the Internalizing and Externalizing factors (i.e., above the 90th percentile for the normative, non-clinical group) than children who were housed (Internalizing: 23% vs. 9%, Externalizing: 18% vs. 6%, respectively).[17] High scores on these factors indicate the concentration of behaviors, especially aggressive behaviors, that contribute to high overall behavior problem scores.

Table 10 shows that the percentage of housed children above the clinical cut-offs for Internalizing and Externalizing approximated that of the non-clinical standardization sample, whereas the homeless group fell between the non-clinical and clinical samples. (See Figure 3 for graphic representation of this relationship.)

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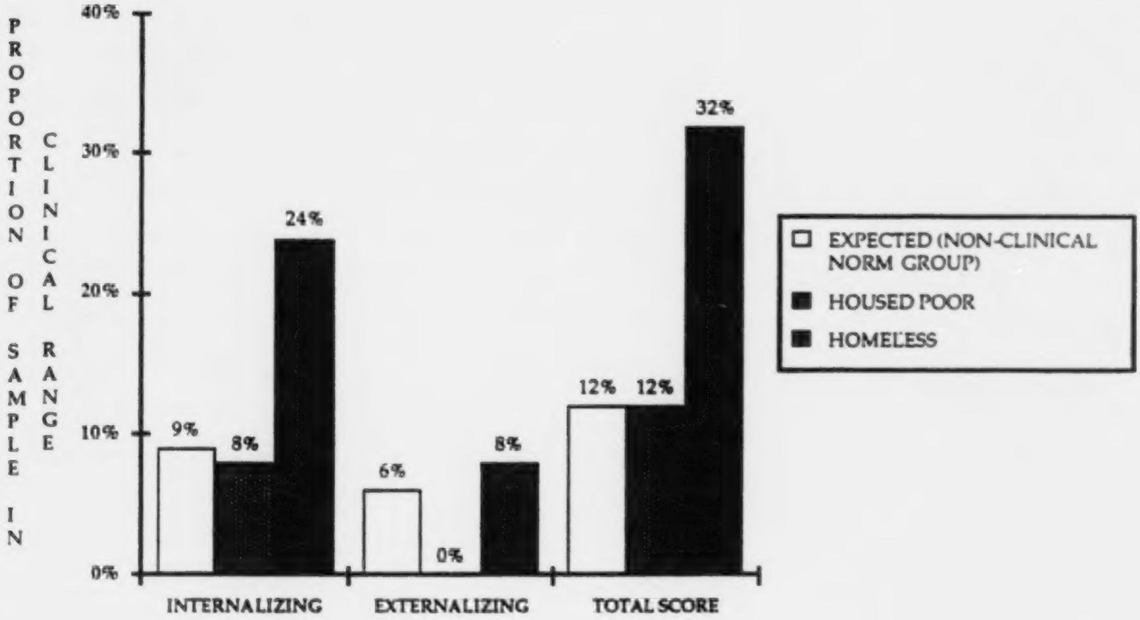
[16] $X^2(1, N = 98) = 6.68, p < .01$.

[17] Internalizing: $X^2(1, N = 98) = 3.70, p = .06$; Externalizing: $X^2(1, N = 96) = 2.89, p = .09$.

Figure 3

Children with Scores Above the Clinical Cut-Off on the Child Behavior Checklist (CBCL)

A. 4- and 5-Year-Old Girls



B. 4- and 5-Year-Old Boys

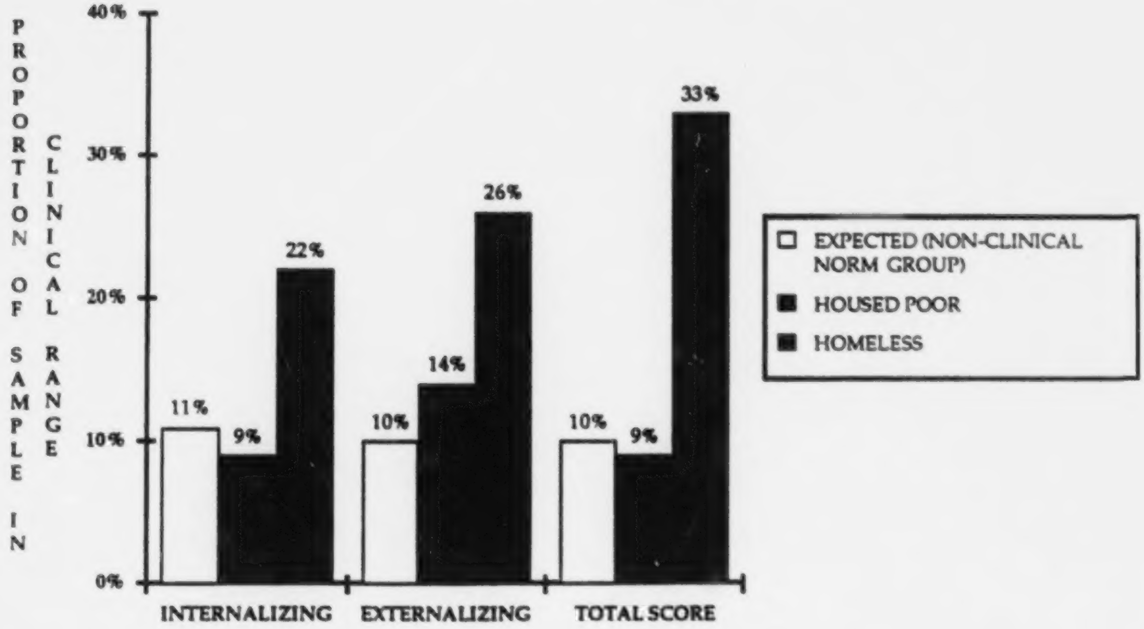


Table 10

Percent of 4- to 6-Year-Olds from Clinical and Non-Clinical Samples[a] Who Scored in the "Clinical Range[b]" on the Scales of the Child Behavior Checklist (CBCL)

- Comparisons with the NYFSP -

	BOYS				GIRLS			
	Norm Group		NYFSP		Norm Group		NYFSP	
	Clin. (N=100)	Non-Clin. (N=100)	Housed (N=22)	Homeless (N=27)	Clin. (N=100)	Non-Clin. (N=100)	Housed (N=24)	Homeless (N=25)
SCALE SCORES								
Social withdrawal	37	3	5	7	29	2	0	4
Depressed	37	4	5	11	23	2	8	0
Somatic problems	25	3	5	11	25	2	0	12
Aggressive	61	6	5	22	32	2	0	8
Immature	42	3	5	7	--[c]	--	--	--
Sex problems	14	0	0	0	13	3	0	0
Schizoid	14	2	5	4	31	3	0	0
Delinquent	29	2	0	15	--	--	--	--
Obese	--	--	--	--	18	2	0	8
Hyperactive	--	--	--	--	27	2	4	0
>1 Scale in clinical range	76	11	18	33	65	9	8	20
FACTOR SCORES								
Internalizing	59	11	9	22	68	9	8	24
Externalizing	62	10	14	26	42	6	0	8
TOTAL SCORE	72	10	9	33	73	12	12	32

[a] Normative and clinical scores are those of the age sub-samples used in the norming of the CBCL (see Achenbach & Edelbrock, 1983). Since only two NYFSP 3-year-olds (1 housed, 1 homeless) scored above the clinical cut-off, that age group is not represented in this table.

[b] Clinical range: Scale scores above the 98th percentile. Total scores above the 90th percentile.

[c] Not all scales apply to both boys and girls. A dash indicates a non-applicable scale for that sex.

Again, what this means is that homeless children do not behave like a normative sample -- or even like their poor, housed counterparts. As can be seen, this pattern prevails on the ten narrow-band scales as well. (Clinical cut-offs for the narrow-band scales are at the 98% percentile for nonreferred children.) While lower than the rates of a sample being referred for mental health services, the higher incidence of reported behavioral problems among the homeless group is a disturbing finding.

Of the 17 homeless children whose total score was above the clinical cut-off, nine scored above the clinical cut-off for internalizing behaviors, eight for externalizing behaviors, and five were above the clinical cut-off on both factors. Certain sex differences were suggested as well. Boys and girls exhibited different patterns of problem behaviors. Figures 4 and 5 show that boys scored relatively higher on those scales reflecting externalizing, antisocial behavior (e.g., Aggressive and Delinquent behaviors), and girls scored slightly higher on those scales reflecting internalizing, fearful behaviors (e.g., Somatic Complaints, and Schizoid/Anxious behaviors).

Relationship Between the CBCL and the ESI

Because the CBCL taps behavioral/emotional problems that are independent of developmental domains, a relationship between the CBCL and the ESI would not necessarily be expected. Clearly, however, extremes on either measure could affect scores on the other. For example, extreme behavior problems could interfere with the disposition to learn; extreme developmental levels (either well above or below the norm) could lead to frustration expressed through acting-out behaviors. Thus, it is reasonable to expect a negative relationship between the two measures. Specifically, the higher the rate of behavioral/emotional problems indicated on the CBCL, especially as expressed through externalizing behaviors, the lower the developmental score on the ESI.[18] However, closer examination showed that this relationship only held for the non-ECE group.[19] Although more information is needed to explain this, it may be that ECE tempers the influence of behavioral problems on overall developmental progress by offering a counterbalance of

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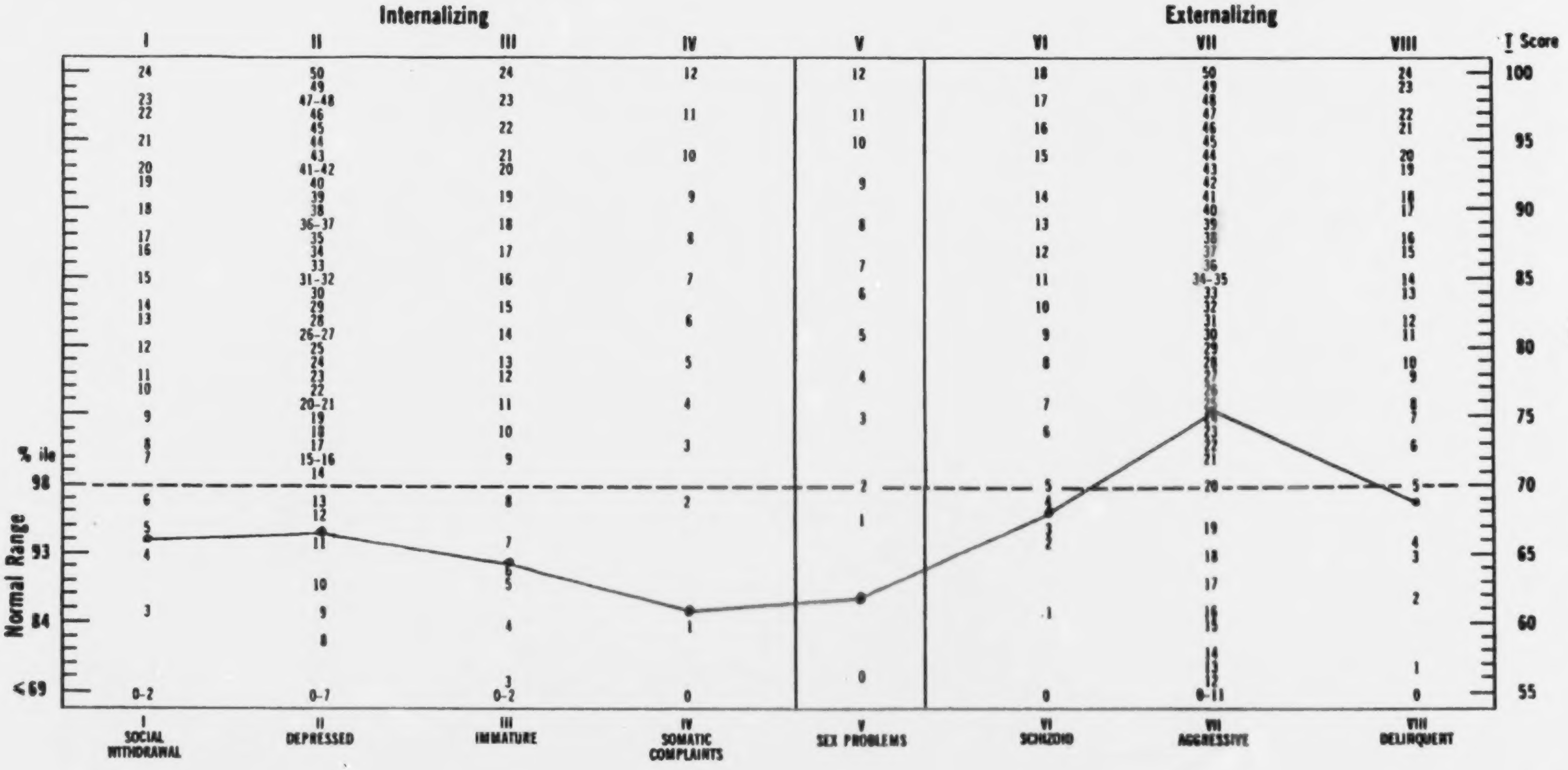
[18] Though just short of significant, there was a negative correlation between the total CBCL score and the ESI score: $r = -.16$, $p = .056$; and a significant negative correlation between the Externalizing sub-score on the CBCL and the total ESI score: $r = -.25$, $p < .005$.

[19] For children enrolled in day care or Head Start, there was no relationship between their ESI score and their CBCL total score or Internalizing/Externalizing factor scores. However, for children not exposed to ECE, there was a significant negative relationship between their ESI score and CBCL total score ($r = -.36$, $p < .01$) and CBCL Externalizing score ($r = -.46$, $p = .001$). There were no sex differences.

Figure 4

Scale Scores for Children in the Clinical Range on the Child Behavior Checklist (CBCL)

Homeless Boys Aged 4 - 5

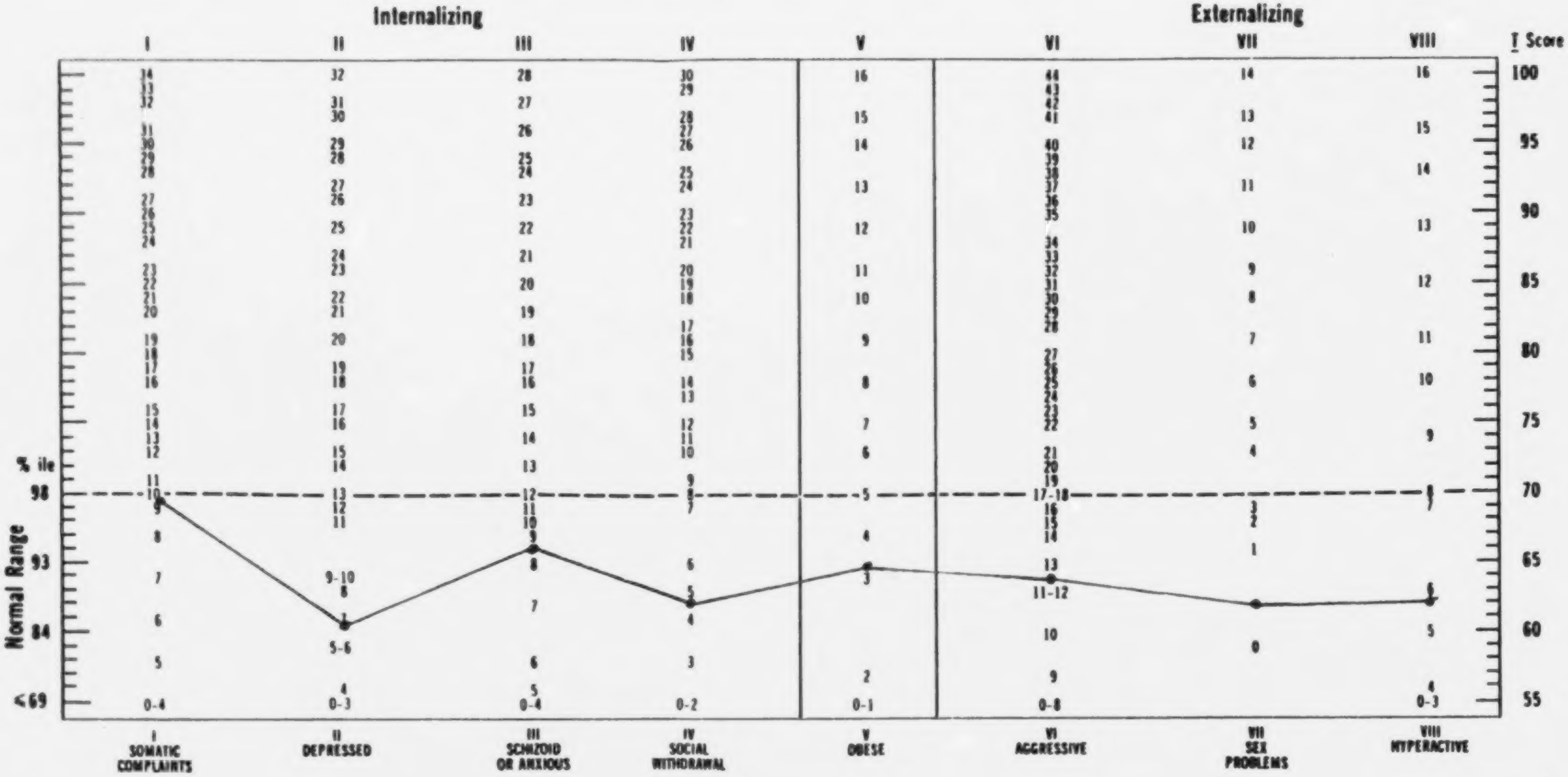


Note: N = 9.

Scale Scores for Children in the Clinical Range on the Child Behavior Checklist (CBCL)

Homeless Girls Aged 4 - 5

Figure 5



Note: N = 8.

positive experiences. If so, this provides an additional argument for the expansion of early childhood programs for at-risk children.

The Impact of Family Background Variables

As with the ESI, there were no differences in CBCL scores -- either total raw scores or Internalizing/Externalizing factors -- that were related to race/ethnicity, or the mother's educational level, work history, or age.

Environmental Influences on Behavior

Although their developmental profiles (as captured by performance on the ESI) were indistinguishable, the behavioral profiles of children differed as a function of their housing status. A fundamental question posed by this differential pattern of results is: Were the homeless children who scored above the clinical cut-off really emotionally disturbed and needing mental health services, or were their problem behaviors situationally determined? In other words, could this pathology be considered environmentally driven? Is the homeless group a non-clinical sample exhibiting clinical behaviors in reaction to the stresses produced by the condition of homelessness? If so, is the solution to the problem a mental health intervention or an apartment? And if the appropriate intervention is not forthcoming, could some of these behaviors become ingrained patterns within a child's behavioral repertoire? That is, without intervention -- probably a combination of mental health intervention as well as permanent housing -- a good number of these children may be developing mental health problems that could interfere with their overall development over the long term.

Additional insight on this point was offered to us by some of the mothers we interviewed. As part of the general interview protocol, mothers living in shelters and hotels were asked what impact, if any, the experience of homelessness had on their children. Some (N = 18) felt that it had no effect, that their children were too small -- "This is the only life he knows," said one mother of her young son -- that it's the older children who feel the embarrassment, the humiliation, and the shame that go with being homeless and living in a hotel or shelter. A few mothers (N = 3) said that homelessness did not have an impact because the conditions were no different than before. A few (N = 4) even said that, yes, there were impacts, but they were positive ones, primarily because of service linkages now in place that had not been in place before. But, of the 60 homeless mothers who were asked this question,[20] half mentioned negative impacts similar to those tapped by the CBCL; e.g., fearfulness, nervousness, withdrawal, changes in eating and sleeping habits, whining, disobedience, and lots of fighting.

> "They have been affected greatly in the hotel. They complained that it was too ugly and too dirty. They were also affected emotionally. They ate and slept less."
>
> "My son has become loud and hard-headed. He's using bad words and doing bad things....He has nowhere to ride his bike."
>
> "My child is fighting. There are lots of opportunities to get into fights and encourage hostility."
>
> "[Especially] in the beginning, it was difficult for them. They were confused, they couldn't sleep. My son became withdrawn."
>
> "They've learned that bad things can happen to anyone."

Moving, by itself, is known to be stressful. Research has shown that preschoolers who are transferred to new child care classes or programs experience increases in negative affect, activity level, physical aggression, and sleep disturbances at the time of the move (cf Howes, 1987). Moving into a chaotic, overcrowded, and uncertain environment can only intensify the emotional stress.

In particular, mothers felt that their children were negatively affected by the cramped space. Said one mother:

> "The children seem different in the one room. They are withdrawn, especially my older one....When they get outside, they act as if they haven't been out in years. In the room, they fight constantly."

Said another mother, quite simply, "Kids feel trapped." They also worry. They worry about the basics. This is 4 and a half-year-old Michael, "When are we going to move? Will I have my own room? Will I get my toys back?"

CHILD HEALTH

As Table 11 shows, neither the housed nor homeless sample were in the best of health. Moreover, consistent with existing data, the incidences of certain conditions (diarrhea, upper respiratory infections) are significantly higher among the homeless than housed groups.[21] However, the similarities outweighed the

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[20] This question was a late addition to the protocol.

[21] Diarrhea: $X^2(1, N = 158) = 5.48, p < .025$. Upper respiratory infection: $X^2(1, N = 158) = 8.32, p < .005$.

Table 11

Health Status of Target Child

	Housed		Homeless	
	N	(%)	N	(%)
Acute Conditions				
In the past year, at least one incidence of				
• Diarrhea	25	33	43	52*
• Upper respiratory infections	6	8	21	26***
• Skin rash	11	14	18	22
• Ear infection	39	51	34	41
Hospitalized at least once in past year	6	8	9	11
Chronic Conditions				
Asthma	11	14	17	20
Sickle Cell	6	8	4	5
Anemia	19	25	18	22
Physical disability	1	1	2	2
Other chronic illness	5	7	5	7
Birth Conditions				
Premature birth	7	9	11	13
Low birthweight	10	13	12	14
Average birthweight	6.9 lbs.		6.8 lbs.	

*$p < .05$

***$p < .005$

differences. Both groups experienced relatively high rates of certain chronic conditions. According to maternal report, one in five children had asthma. One in four was anemic. At birth, almost one in six (13% of the housed children, 16% of the homeless children) was low birthweight (less than 2500 grams). This well exceeded the overall New York City rate of 9% in 1986 (Mayor's Commission on the Future of Child Health in New York City, 1989). It was also higher than the national rate of low birthweight which, in 1987, was 6.9% of all infants (Chiles, 1990). In short, many of the children in this sample did not start life with maximum advantage. Certainly, their present circumstances are not allowing them to live up to their full potential -- physically or developmentally.

FAMILY OUTCOMES

This chapter presents data on elements of the family context for those housed and homeless families who participated in this study -- with a particular focus on maternal depression, significant life events, social supports, and service linkages. The title of this chapter is largely a misnomer, for it assumes unidirectionality -- consequence -- where bidirectionality, or at least mutual interdependence among variables, is more the rule than the exception. In particular, maternal depression is a key variable with respect to child development, with links to eventful life experiences and social supports as well as the primary variables of concern here -- homelessness and chronic poverty. Thus, we begin with it, prior to discussing other aspects of the families' lives.

MATERNAL DEPRESSION

"Some days, I've just wanted to yell out, 'Why me?'" So summarized one of our respondents about her life. One of the most reliable predictors of mental health problems -- particularly depressive symptomatology -- is poverty/economic stress (Belle, 1990). Poverty, especially among blacks, is becoming increasingly ghettoized, with a far more intensive concentration of poor people living together than ever before (Wilson, 1987). Thus, the economic stress of poverty does not occur by itself but goes hand in hand with poor housing, high crime, and a weakened community infrastructure (lower-quality schools, inadequate health facilities, even less frequent garbage pickup). Among families who had lost their housing, we expected an even greater sense of despair, as reflected in the depressive symptomatology rated by the Center for Epidemiologic Studies Depression (CES-D) Scale.

This expectation was only partially confirmed. Instead of homeless families exhibiting higher rates of depression, both housed and homeless families evidenced equally serious manifestations of the daily frustrations, anxieties, and sense of helplessness that profound poverty imposes. Figure 6, for example, shows graphically that the mothers we interviewed -- irrespective of housing status -- reported an alarmingly high rate of referable depressive symptomatology, as measured by the CES-D Scale. (The striking similarity between the distribution of CES-D scores, for housed and homeless families graphed separately, can be found in Appendix F.) Forty-two percent of the families who were homeless and 40% of the

Figure 6

Histogram of Center for Epidemiologic Studies Depression (CES-D) Scale Total Scores

```
Count    Midpoint
  8        1.00    --------------------
  9        3.00    ----------------------
 11        5.00    ---------------------------
  8        7.00    --------------------
 12        9.00    ------------------------------
 13       11.00    --------------------------------
 13       13.00    --------------------------------
 13       15.00    --------------------------------
 14       17.00    -----------------------------------
  7       19.00    -----------------
 15       21.00    -------------------------------------
  4       23.00    ----------
  8       25.00    --------------------
  3       27.00    -------
  4       29.00    ----------
  1       31.00    --
  2       33.00    -----
  2       35.00    -----
  2       37.00    -----
  3       39.00    -------
  3       41.00    -------
  3       43.00    -------
  0       45.00
  2       47.00    -----
                   I ....+ .... I .... + .... I .... + .... I .... + .... I .... + .... I
                   0            4             8            12            16            20
                              Number of Respondents
```

Total N = 160

Note: The graph represents scores for the total sample (housed and homeless), based on a scale ranging from 0-60.

- Referral cutoff point: A score of 16 or higher indicates the need for referral for further psychological assessment.

housed families scored at or above the cut-off score of 16, indicating a need for referral for further psychological assessment.[1]

There were, however, a few patterns which, by definition, were unique to the homeless sample. For instance, among families who were homeless, there was a significant positive correlation between the respondent's CES-D score and number of prior incidences of homelessness; mothers who had experienced more homeless episodes had higher depression scores.[2] "It's made me feel like I can't do anything, I feel useless," said Gloria. This was her second episode of homelessness.

In addition, homeless mothers who reported that they did not know how much longer they might be homeless had significantly higher depression scores than mothers who could mark time until what they thought might be the end of their experience.[3] Directionality of the latter finding is problematic, however. Perhaps depressed individuals are more likely not to care about a future-oriented question, and therefore shrug their shoulders and say they don't know the answer. Or maybe the experience of homelessness as open-ended and of unknown duration leads to more depressive symptomatology. Unfortunately, we lack evidence to speculate further.

Comparison to a National Data Base

Table 12 compares NYFSP responses on selected CES-D items to those from the Health and Nutrition Examination Survey (HANES), a national survey of 17.3% of the U.S. adult population, aged 25-74 years, conducted by the National Center for Health Statistics in 1974-75 (data cited in Rossi, 1989, p. 149). A high score represents responses indicating depression; a total score (derived from all 20 CES-D items) of 16 or higher indicates a need for further psychological assessment.

Although similar to each other, the housed and homeless NYFSP samples scored higher than the national HANES sample on each of the six items in Table 12. NYFSP data differed most strongly on those items most indicative of demoralization ("tired/worn out," "depressed," and "unhappy"). Rossi (1989) speculated that "if the homeless condition can be said to engender mental illness,

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[1] The group means were indistinguishable as well. Both housed and homeless mothers had group means at the cut-off score of 16 (15.3, S.D. = 10.4, range = 0 - 41; and 16.7, S.D. = 11.3, range = 0 - 48; respectively).

[2] $r = .26, p = .019$.

[3] Mean score = 23.0, compared to the overall homeless group mean of 16.7. $F(5,82) = 3.47, p < .01$.

Table 12

Comparison of the NYFSP and HANES Samples on Selected CES-D Items[a]

CES-D Item	NYFSP Housed (N = 76)	NYFSP Homeless (N = 84)	National HANES[b] (N = 107 million)
Poor appetite	0.78	0.84	0.30
Tired/worn out	1.26	1.46	0.60
Depressed	1.05	1.27	0.45
Unhappy	1.14	1.08	0.20
Worried about future	1.26	0.99	0.89
Lonely	0.97	0.93	0.38
Total Score[c]	**15.32**	**16.69**	**8.50**

Note: The Health and Nutrition Examination Survey (HANES) was conducted in 1974-75 by the National Center for Health Statistics to assess depressive symptomatology among non-institutionalized civilian adults 25-74 years of age (see Sayetta & Johnson, 1980).

[a] Mean scores are computed by giving numerical values to each of the four possible response categories: 0 = rarely or none of the time, 3 = most or all of the time.

[b] Cited in Rossi (1989) p. 149.

[c] Maximum score = 60.

demoralization appears to be the most likely mechanism through which it has this effect, for the homeless clearly lack even the most common resources that others take for granted" (p. 148). However, it remains important to note that the housed families on public assistance in the NYFSP sample were, on average, no better off in terms of depressive symptomatology than the families who were homeless.

The Relation of Maternal Depression to Child Outcomes

Consistent with findings from other research using the Child Behavior Checklist (CBCL) (Friedlander, Weiss, & Traylor, 1986; Richters & Pellegrini, 1989), depressed NYFSP respondents -- irrespective of housing status -- reported more and different kinds of behavior problems in their children. This relationship was indicated by a significant positive correlation between mothers' scores on the CES-D and child behavior problems as measured by the CBCL total problem score.[4]

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[4] $r=.23$, $p<.05$ for the housed mothers and $r=.41$, $p<.001$ for the homeless mothers.

Although it was not possible in this study to parcel out the extent to which a mother's depressed state may have colored her perceptions about her child's behavior -- either by making her more sensitive to negative behaviors, or by making her feel more generally negative about life in general, including her child, independent of the child's actual behaviors -- other researchers have. For example, Richters and Pellegrini (1989) compared mothers' CBCL ratings of their 9-year-old children with ratings made by the children's teachers. Teacher ratings essentially matched those of the mothers, which in turn were related to depressive diagnosis. Children of depressed mothers were independently rated by both their mothers and teachers as having significantly more behavioral problems than children of non-depressed mothers.[5]

Dolores Whitney and her son, James, were an extreme example of the relationship between maternal depression and child behavior.

> Dolores Whitney, age 37, scored a 42 out of a maximum possible score of 60 on the CES-D. (The cut-off score for psychological referral is 16.) She indicated she felt depressed "all the time, not just this week" (the timeframe for the CES-D). Outside of her interactions with her children, she was an extremely isolated, lonely person. For example, in response to the item, "I felt that people disliked me," she answered, "I don't know, I keep away from other people." To the item, "I talked less than usual," she responded, "I don't ever talk much."
>
> Her son, James, was the fifth of seven children. His CBCL score of 68 was among the highest in the NYFSP sample. (The clinical cut-off is 42.) Dolores called him a "bad child," "stubborn," and "dangerous," whom she was afraid to leave alone. She described a number of disturbing behaviors. He liked to turn on the stove, he liked hot things. When he was 3, he poured hot oil on an older brother (Dolores didn't take the child to the hospital for fear of being reported for child abuse). Recently, he burned a younger sibling with an iron. He fought a lot, and "always wants his own way." His anxiety was at such a level that he would pull out his hair. When asked, as part of the ESI Parent Questionnaire, to describe the best things about James, Dolores laughed. "What do you mean? I don't know of any." (After thinking awhile, she mentioned certain household tasks, like getting Pampers, emptying the garbage, etc.)
>
> Although he was enrolled in day care, James had poor attendance. The day care center was located on the first floor of the Tier II shelter in which James and his family lived. But, frequently Dolores was unable to

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[5] In spite of evidence such as this, the independence of psychological state on maternal ratings of child behavior has not been adequately established.

get out of bed and take him downstairs. James' ESI score of 13 was, for his age (4 years, 4 months), in the "Rescreen" range.

Although not completely understood, the relationship between maternal depression and children's socioemotional development has been well documented in the psychological literature. Much of it assumes that maternal depression leads to a disturbance in the parent-child relationship, which in turn leads to child maladjustment. For example, the Stress and Families Project, a study of 43 low-income Boston-area mothers with children aged 5 through 7, found that depressed mothers, compared to nondepressed mothers, were more likely to use hostile and dominating styles when interacting with their children, and less likely to use styles that conveyed warmth, affection, or positive affect (Longfellow et al., 1982). Such power-assertive parenting techniques have been linked to children's socioemotional dysfunctioning (McLoyd, 1990). In addition, the psychological distancing and withdrawal characteristic of depression reduces reciprocal interaction between mother and child. It has been found, for example, to be related to insecure mother-child attachments (Radke-Yarrow, et al., 1985) which in turn can have long-term impact on the child's social relationships and overall socioemotional functioning.

Mothers are not oblivious of the potential impact of their affective state on their children. The depressed mothers in the Stress and Families Project believed that their depression affected the way they acted with their children. In particular, they reported that among the hardest things to do when feeling depressed were being patient, nurturant, and actively involved with their children.

However, the presumption of such a significant influence of the mother's emotional state on child development has been challenged. Dodge (1990) suggested that, instead of a unidirectional model of transmission -- from parental distress, to impaired parenting behavior, to child dysfunction -- the relationship between maternal depression and child maladjustment may be bidirectional (e.g., child temperament and other child characteristics may influence the mother's reaction to the child), and/or interactional (i.e., the nature of the child's response to the mother's psychological state may in turn elicit negative or flat affect from the mother), or maybe not be causally-linked at all, as might be the case when parent and child are independently influenced by a "shared environment" of stressors. Rutter (1990) has also identified variables that may need to be included in a comprehensive model of child functioning and maternal distress, including the role of the child's level of social competence and other protective factors in attenuating the negative impact of maternal depression. Clearly, much remains to be learned regarding the particular mechanisms or processes through which the observed relationship between maternal depression and child functioning manifests itself.

LIFE EVENTS

> Barbara Lincoln keeps to herself. She says that people tell her she looks evil. At age 36, she does look weather-beaten. Her front teeth are rotting; she is missing two of them. "But when you try to get friendly, that's when the trouble starts." During the past year, she lost the most significant person in her life -- her mother -- about whom she couldn't talk without breaking down. Two weeks before being interviewed, she was jumped by four teenage girls in front of the homeless shelter in which she and her children lived. Although it turned out be "a case of mistaken identity," she was badly beaten. The assault caused her to miscarry a baby she was ambivalent about carrying in the first place. Did she report the incident? "No, I was too scared. When it's just you and your kids, what can you do?"
>
> Other significant life events in Barbara's life over the past year: her partner of 17 years was sent to jail; she began and ended another relationship; and her first grandchild was born.

The Norbeck Life Events Questionnaire was used to record significant life events that had occurred in the lives of NYFSP families in the 12 months prior to being interviewed. Both positive and negative events -- as so judged by the respondents -- were recorded, in recognition of the fact that major life events are stress-producing even when they are greeted with joy (e.g., moving into a new home, the birth of a child).

Barbara Lincoln's score on the Life Events Questionnaire was equal to the mean for the homeless families in our sample. Families who were homeless experienced an average of nine significant life events (S.D. = 4.1, range = 0 to 17) over the course of the 12 months prior to being interviewed. This was two more per year than among housed families (S.D. = 5.3, range = 0 to 24), a statistically significant difference.[6] Not only did families who were homeless experience significantly more life events than families who were housed, but they experienced significantly more negative life events (5 vs. 4, respectively).[7]

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[6] $t(158) = 2.17, p < .05$.

[7] $t(158) = 2.21, p < .05$. Housed: S.D. = 3.3, range = 0 to 16; homeless: S.D. = 3.0, range = 0 to 15.

However, notwithstanding the differences between groups, the means for both -- housed families as well as those who were homeless -- were well above the one to two events per year reported in community surveys among the general population (cf Makosky, 1982). The bottom line clearly seems to be poverty. Poor women experience more frequent, more threatening, and more uncontrollable life events than does the general population (Belle, 1990). The women in our study certainly did.

Table 13 highlights some of the significant life events reported by families as having occurred during the past 12 months. The two events reported by the greatest number of women -- most particularly those who were homeless -- were loss or damage of personal property (39%), and separation from spouse or partner (37%). The former is not surprising, indeed seems low, given the reputation shelters have as dangerous havens from the streets. With regard to the latter, for some women (6%), the immediate precipitant of homelessness was leaving a partner because of domestic violence. In addition, shelter living itself, particularly the restriction

Table 13

Selected[a] Life Events Reported by NYFSP Families

Life Event	Housed (N = 76)		Homeless (N = 84)	
In the past 12 months, experienced:	**N**	**(%)**	**N**	**(%)**
Pregnancy	13	(17)	26	(31)
Miscarriage or abortion	12	(16)	14	(17)
Gain of a new family member (through birth, adoption, relative moving in, etc.)	19	(25)	30	(36)
Birth of a grandchild	4	(5)	4	(5)
Began a new close, personal relationship	18	(24)	26	(31)
Made new friends	33	(43)	54	(64)
Separation from spouse or partner	21	(28)	31	(37)
Death of spouse or partner	3	(4)	3	(4)
Death of a child	0	(0)	2	(2)
Death of a family member or close friend	20	(26)	19	(23)
Loss or damage of personal property	10	(13)	33	(39)
Victim of a violent act (rape, assault, ect.)	4	(5)	12	(14)
Major personal illness or injury	13	(17)	19	(23)

Note: Percentages do not sum to 100, because respondents could indicate multiple events.

[a] This is not an exhaustive list. It represents 13 of the 38 items on the Norbeck Life Events Questionnaire.

against men in some Tier II facilities, may actively work against the maintenance of a relationship. Unfortunately, we did not ask respondents who were homeless to differentiate between events that occurred during or prior to becoming homeless. It is possible that traumatic events prior to homelessness wore down the resilience of families, making them more vulnerable to losing their homes; or that the condition of homelessness brings with it its own multiple disruptions and crises -- or both.

At the same time, all was not bleak. The birth of a grandchild was viewed by all eight grandmothers as a positive event. Six women mentioned a positive change in their religious beliefs. Making new friends was a mixed blessing -- but mostly good -- as was beginning a new, close relationship. Indeed, both housed and homeless groups reported having experienced close to four good events in the past year.

The number of significant life events, especially negative events, reported by both groups may well have been higher had we modified the Norbeck Life Events Questionnaire to include more events common to low-income populations, for example, welfare case closings, eviction, arrest of a family member or close friend, beginning or ceasing drug treatment, and so on. However, notwithstanding the importance of this information in understanding the complexities of peoples' lives, a focus on events is limited. Certainly, sudden change (positive or negative) is known to be stressful. However, it is becoming increasingly clear that "much of the stress in life comes not from the necessity of adjusting to sporadic change, but from steady, unchanging oppressive conditions, which must be endured daily" (Makosky, 1982, p. 36). This includes chronic life conditions such as financial burdens, single-parent caretaking responsibilities, inadequate housing and dangerous neighborhoods; in short, many of the conditions that accompany poverty.

Even homelessness is, for many families, a condition rather an event. Whereas *becoming* homeless, like losing a job, is obviously an event; *being* homeless, like ongoing unemployment, is a condition. This is especially so for families like those in the present study who, when interviewed, had been in the emergency shelter system an average of 12 months, and some for as long as two and three years.

Homelessness dramatically affected some of the women we interviewed. Sixty-nine of the 84 homeless women were asked how they were affected by being homeless. One-quarter of them referred to the stress of being homeless and the depression and bad feelings it engendered. "It's had a great impact. I feel terrible, as if I'm in another world," said one respondent. "I fear for my kids, I fear for me. All I think about is the day it will be over," said another. One women summarized the experience as "just plain bad." Combining the conditions of homelessness (violence, isolation, instability) with the effects of the event that precipitated it (eviction, fire, abuse) and the events that often accompany loss of housing (leaving a neighborhood, changing schools, losing possessions, disrupting social networks), extends in impact far beyond what would be represented in the coding of a single "event" of homelessness.

The Relation of Life Events to Other Variables

Maternal Depression. In the context of chronically stressful ongoing life conditions, the connection of negative life events to mental health seems strong. For the full sample, there was a significant positive correlation between the number of negative life events which mothers reported and their level of depressive symptomatology, as measured by the CES-D Scale.[8] The more negative life events, the higher the CES-D score.

These findings are consistent with data from the Community Mental Health Assessment Project (CMHA) project, which also used the CES-D. Although the CMHA samples (located in Washington County, MD and Kansas City, MO) had lower CES-D and life events scores than found in our study, the pattern of the relationship was the same as we found: the higher the "life change unit," the higher the level of reported depression (Markush & Favero, 1974).

However, this does nothing to explain the dynamics of the relationship. In other words, is it the occurrence of significant events, especially negative events *per se*, or chronic life stress that is driving up depression scores? Some studies have found little relationship between life events and psychological distress after chronic stressors are taken into account. The Stress and Families' Project, mentioned earlier, found that psychological well-being among low-income Boston women was more strongly related to life conditions than to life events (Makosky, 1982). In particular, the most stressful area identified was finances.[9] Because money can buffer the impact of many of life's unpleasant surprises (eviction, job loss, sudden illness, death of a breadwinner), its absence often precipitates additional crises, such that stressful life events occur almost as if "contagious." Indeed, Dressler (1985) found that chronic economic stress was the strongest predictor of depression among black families living in a small southern city. Deep poverty characterized the entire

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[8] $r = .39, p < .001$.

[9] Next, in order of stressfulness, were parenting, living conditions, and intimate relationships (Makosky, 1982).

80

NYFSP sample. So did high rates of negative life events and high overall levels of depressive symptomatology.

Child Behavior. There was no relationship between the number of significant life events experienced by families and children's scores on the Early Screening Inventory. However, consistent with the existence of positive correlations between maternal depression and child behavior problems, and between maternal depression and life events, there were positive correlations between the number of life events the mother reported -- both total events and negative events -- and her child's score on the Child Behavior Checklist (CBCL).[10] That is, the more events a family had experienced over the past 12 months, the more child behavior problems the mother reported. This was especially so among families who were homeless.[11] Not surprisingly, the occurrence of negative events is what seemed to make the major contribution to this relationship. Even a few positive events did not offset the influence of the negative events.

The nature of this linkage is not so clear, however. Do life events indirectly affect children via their impact on maternal depression, or do they have a direct impact on children's socioemotional functioning independent of their relationship to the mother's psychological well-being? If poverty is the operant variable here, then perhaps both are the case.

SOCIAL SUPPORT

"Being homeless means no one cares for you, you're lost." During our interviews with families who were homeless, more than one mother spoke to us of her chosen isolation, of going out as little as possible, and avoiding contact with others in the hotel or shelter. "The space, the atmosphere, everybody is angry and malicious, the drugs....it's like hell," said Alicia Perez, 28, who with her two children had lived in the Hamilton Place Hotel for 14 months. Others spoke of being lost and alone, but alone in a very public space. As much as they might keep to themselves, they felt their lives were on display. "Nothing is private, everybody knows your business," is how one mother described it.

Using the Norbeck Social Supports Questionnaire (NSSQ), we asked families to describe various aspects of their social support system, including the number of important people in their lives, who those people were, and the kind of support they gave. In general, there were no differences that distinguished families who were homeless from families who were housed.

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[10] CBCL and total number of life events: $r = .33, p < .001$. CBCL and number of negative life events: $r = .32, p < .001$.

[11] Among homeless families: CBCL and total number of life events: $r = .35, p < .001$. CBCL and number of negative life events: $r = .46, p < .001$.

Network Size

The number of significant people in the lives of the families we interviewed was small. When asked to list "each significant person in your life," housed families listed an average of 5.7 people (S.D. = 2.8, range = 1 to 15), and families who were homeless listed an average of 5.6 people (S.D. = 2.3, range = 0 to 14). The overall distribution is represented in Figure 7. Compared to data collected in the late 1970s by the Harvard Stress and Families Project, these numbers are low. Excluding children, low-income Boston area women reported a social network averaging in size between seven and eight people (Belle, 1982). Excluding children (who, as discussed below, were major sources of support) from NYFSP networks reduced the mean network size to 4.8 and 4.6 members for housed and homeless families, respectively.

There was tremendous variation: some people had remarkably rich and varied networks, while two women, both homeless, listed no one. Of course, numbers alone do not signify. As seen in Table 14, the frequency of contact that respondents had with people they considered significant did not vary according to housing status. About half were daily contacts; another 30% were weekly contacts. Homeless families mentioned only a slightly higher rate of infrequent contacts than families who were housed. With respect to duration of contact, the proportion of longer-term relationships was about the same for both groups -- two-thirds of all relationships listed had lasted for more than five years (see Table 14). However, at the other extreme, 20% of the relationships mentioned by homeless families (compared to 3% of those mentioned by housed families) were less than a year old.

Network Composition

The 160 NYFSP respondents listed a total of 906 people in their social networks. Figures 8A and 8B show that, not surprisingly, the majority of people listed were immediate family (children, parents, and siblings) and other relatives of the respondent. Another quarter were friends and neighbors. Spouses/partners appear as such a small category because they could only be listed once,[12] whereas

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[12] Former partners, with whom the respondent shared parenting status, were coded as "friends."

Figure 7

Number of People in NYFSP Families' Social Support Networks

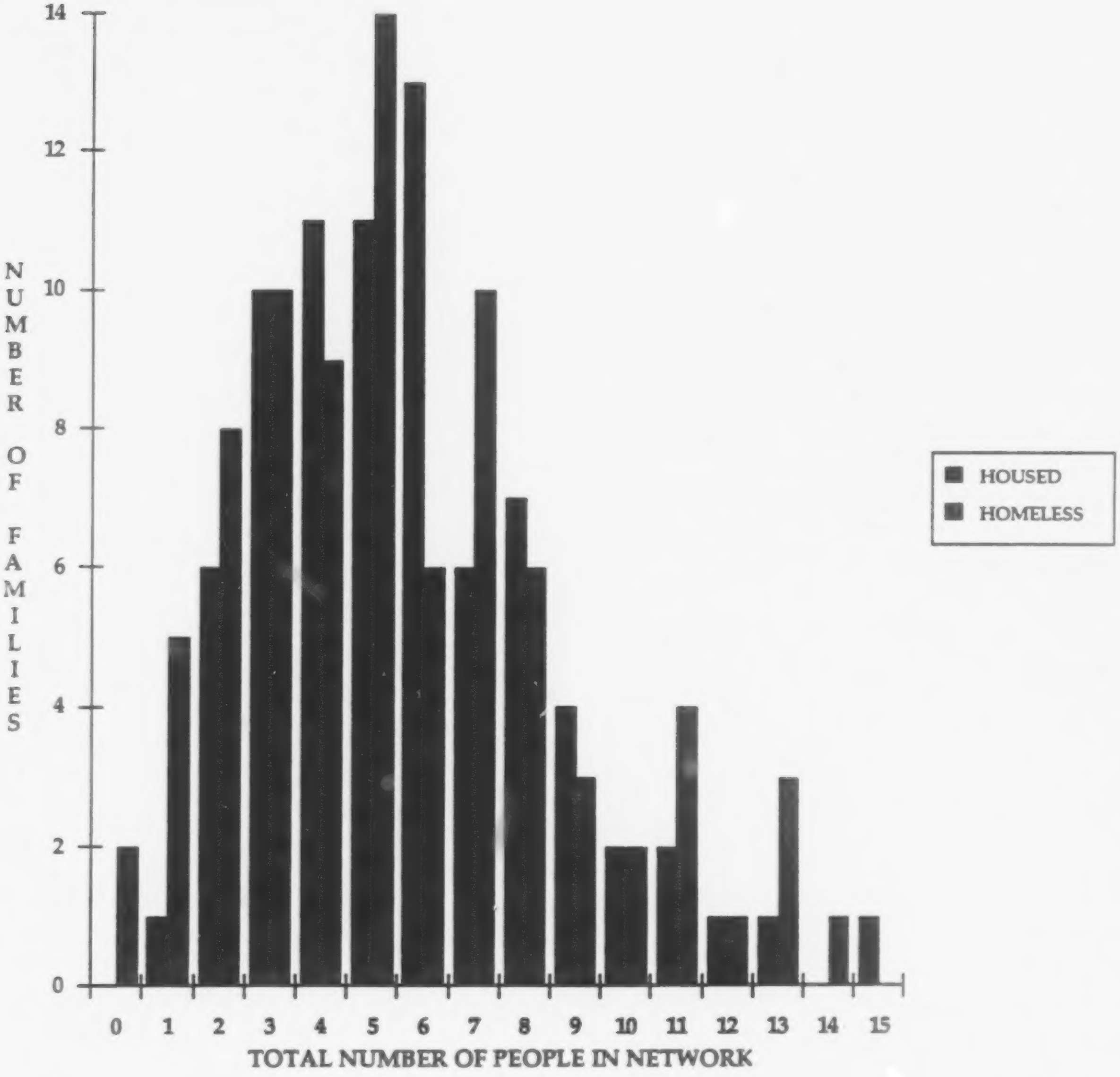

Table 14

Social Support Networks
Frequency and Duration of Contact

	Housed (N = 437)	Homeless (N = 469)	Total (N = 906)
Frequency of Contact (%)			
Daily	55.6%	47.5%	51.5%
Weekly	27.8	32.2	30.0
Monthly	12.4	9.2	10.8
Few times a year	2.8	4.2	3.5
Once a year or less	1.4	7.0	4.2
Duration of Contact (%)			
More than 5 years	70.7%	63.2%	66.9%
2 to 5 years	18.3	11.1	14.6
1 to 2 years	7.6	6.2	6.8
6 to 12 months	3.2	8.5	6.0
less than 6 months	0.2	11.1	5.8

Note: Ns refer to the total number of individuals included in respondents' social networks. Each mother listed an average of 5.6 people.

multiple friends and relatives could be and were listed. Eleven respondents included non-available members in their networks, such as deceased friends or family members from whose memory they still gained support, God (as distinct from "the Church," or religious leaders), and television evangelists.[13] In all, 63% of all persons listed were female, and 37% were male.

Figure 9 presents a different way of looking at network composition, by indicating the proportion of respondents who included at least one person in various categories. The importance of family -- its strong presence or notable absence -- is highlighted even more here than in Figure 8. Three-quarters of the total sample mentioned at least one member of their immediate family (excluding their own children) as significant people in their lives; 25% did not. Thirty-six percent of the mothers who were homeless and 42% of those who were housed included other relatives as well. In contrast to the underrepresentation suggested in Figure 8, spouses/partners were listed by 45% of the respondents. About 40% of the

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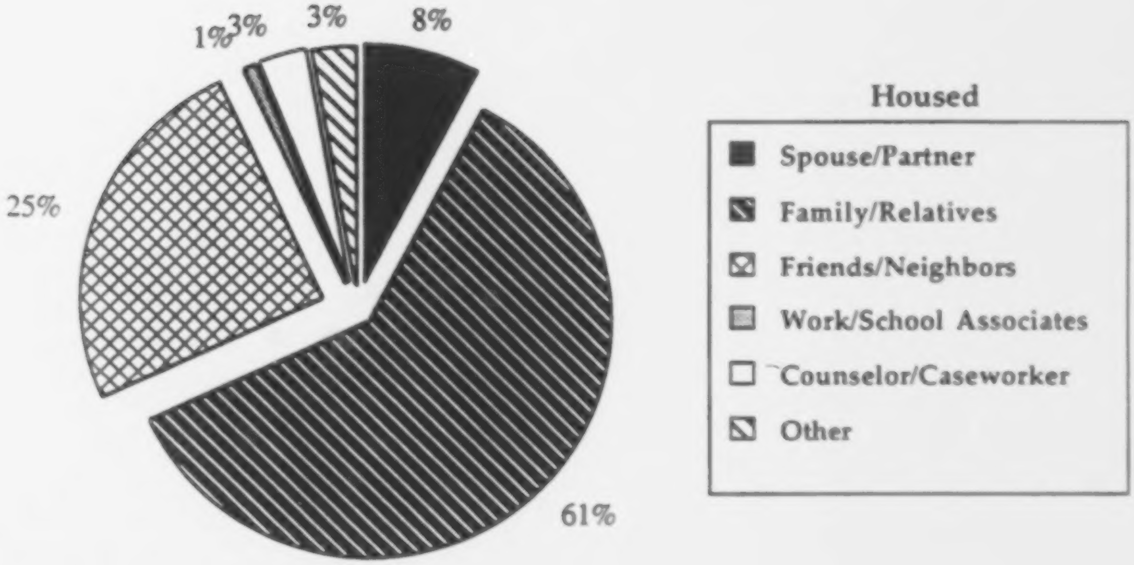
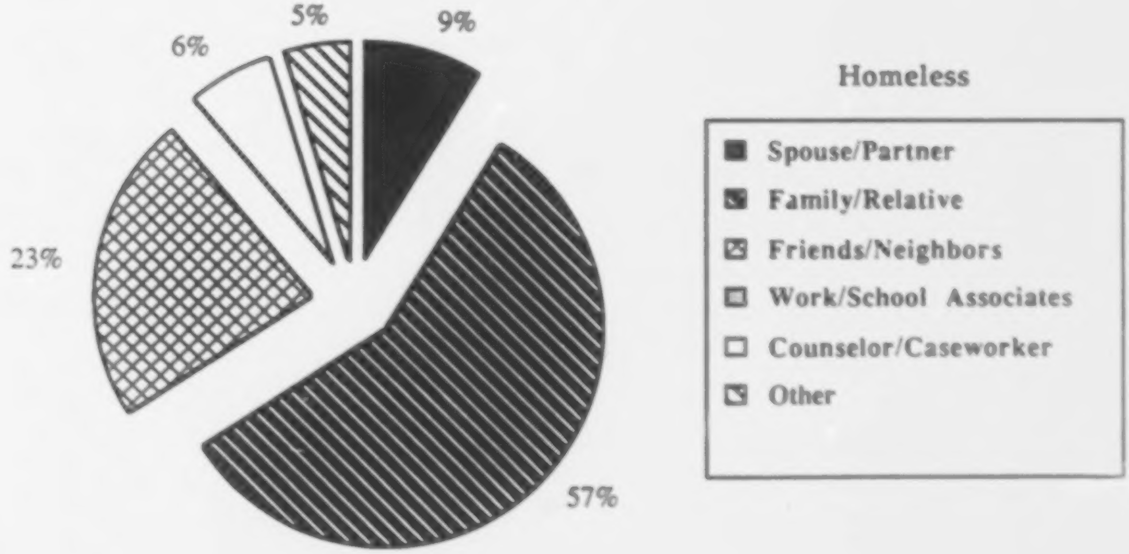
[13] In data analysis, no members, whether living or dead, were eliminated from a person's social network.

Figure 8

Composition of Families' Social Support Networks
Total Distribution



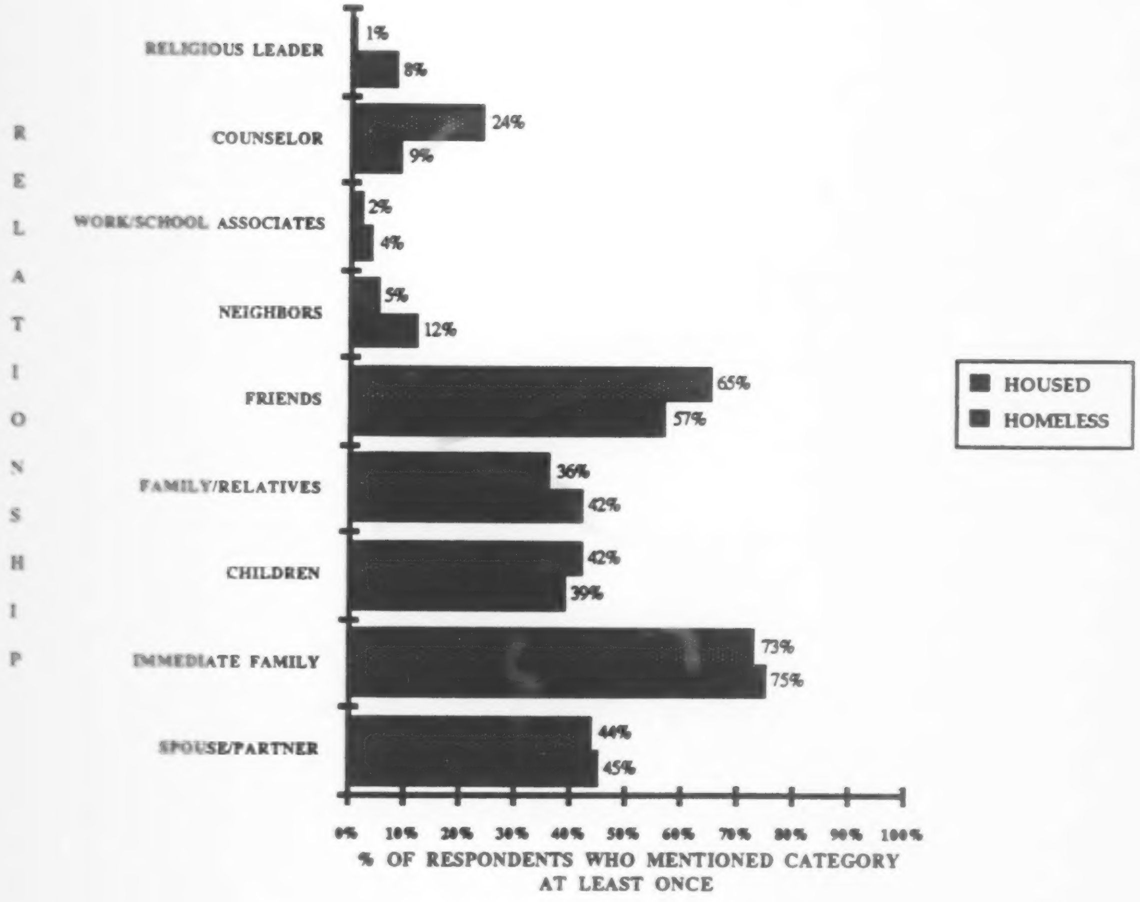
The 76 housed families included a total of 437 people in their social support networks.



The 84 homeless families included a total of 469 people in their social support networks.

Figure 9

Families' Social Support Networks
Selected Members Who were Mentioned at Least Once



sample (42% of those who were homeless and 39% of those who were housed) listed their children.

The majority of respondents (65% and 57% of housed and homeless mothers, respectively) listed at least one friend. Very few respondents listed neighbors. This is not surprising for families living in temporary shelters, of whom only 5% listed neighbors, but the figure of 12% among housed families was lower than expected. Interestingly, 24% of the homeless families, compared to 9% of the housed families, listed a counselor/caseworker as a significant person. Work/school associates were, predictably, of low frequency for both groups of families.

Finally, only 8% of housed families, and a mere 1% of homeless families listed a religious leader (e.g., priest or minister) as a social support. This, however, is not surprising given the low rates of religious participation of the sample as a whole. The majority of respondents (55%) indicated their level of participation in religious activities as "inactive" or "infrequent" (1-2 times a year); 23% categorized their participation as "occasional" (about monthly), and just 19% as "regular" (weekly). One woman we interviewed indicated that she would go to church -- "It doesn't matter which one; God is God" -- but she didn't have "the right kind of clothes for church."

Type of Support

NSSQ questions provide information about emotional support (including both affection and affirmation) and instrumental support, that is, direct aid. There were no mean differences (or differences in the distributions of responses) between housed and homeless respondents in terms of the total level of support they perceived themselves as receiving on these dimensions. What varied was the type of support, across the entire sample, women received from different network members.

Emotional Support. Perhaps the most notable finding in this regard was the major role that children played in providing their mothers with emotional support. As noted above, about 40% of all respondents listed one or more children in their social support networks. More than spouses/partners, immediate or extended family, friends, or neighbors, children were rated almost universally at the high end of the rating scale ("5" on a 5-point scale) for questions about emotional support, especially perceived affection.[14] For example, only 66% of spouses/partners who were listed, compared to 86% of the children who were listed, were described as making the respondents feel "liked or loved...a great deal." "He's my heart," said 3-year-old Joey's mother. "I got Clarissa, I can never be lonely," said Diane about her 4-year-old daughter. Diane listed three people as significant in her life: Clarissa, her mother, and a friend. When asked to what extent she could confide in those people, Diane said about Clarissa, "I tell her everything...[even though] she doesn't even know what I'm saying sometimes." Another mother said about her young child, "She's my favorite. She's the only one who says 'I love you.'"

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[14] NSSQ questions probing affection: "How much does this person make you feel liked or loved? "How much does this person make you feel respected or admired?"

Instrumental Support. Male partners were rated higher on the concrete help they provided than on the affection and affirmation they offered. Indeed, they earned the highest ratings of any other category of person on the three NSSQ questions probing instrumental support in the form of direct help or assistance.[15] On all three questions men consistently (about 75% of them) were rated a "5." Friends, who were also rated higher on instrumental support than on emotional support, were the next most dependable group in terms of how much they could be counted on to help. Family members were given the widest range of ratings. For example, when asked how much they could help if the respondent needed to borrow $10, a ride to the doctor, or some other immediate help, while 58% of immediate family members were rated as being able to provide "a great deal" of help on these specific items, 20% were rated as being able to provide "none at all" or only "a little" help. Whether this was the case through lack of resources, disability, distance, or unwillingness, is not known.

The Relation of Social Supports to Other Variables

Sub-scale scores of the NSSQ -- size of network, ratings of emotional support (including two separate ratings of affection and affirmation), instrumental support, and total support -- were examined in relation to other adult/family variables as well as to child outcomes.

Mothers' Educational Level. Although not statistically significant, mothers who had at least some college education reported higher levels of social support, as indicated by the size of their networks, and their rating of emotional and instrumental support.

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[15] NSSQ questions probing instrumental support:
"If you needed to borrow $10, a ride to the doctor, or some other immediate help, how much could this person usually help?"
"If you were confined to bed for several weeks, how much could this person help you?"
"How much does this person help you with your caregiving responsibilities?"

Life Events. Both the number of positive life events that had occurred in the past 12 months and the intensity of their effect were positively correlated, although at low levels, with the size of the network,[16] and perceived affirmation[17] and aid.[18] Although there are insufficient data for informed speculation, some of the aid and affirmation may themselves have constituted positive life events, especially for example if they came in the form of a new friend or close relationship.

Maternal Depression. The relationship between social support and maternal depression, as measured by the CES-D Scale, was weak. There was a trend among homeless families toward a negative relationship between respondents' scores on the CES-D and the level of instrumental support they perceived themselves as receiving. That is, the higher the CES-D score, the lower the score for concrete aid.[19] But that was the extent of any kind of statistical relationship.

The relationship between social supports and stress is a complex one, especially among low-income populations. It is not a simple linear relationship of the type: the larger the network, the more support, the less stress. Social support, life events, stress, and poverty are all intermeshed. McLoyd (1990) summarized the status of existing research on the relationship between social support and emotional and parental functioning, which suggests that social supports make the most difference when: psychological distress is relatively low, during times of major life transitions, and when the source of stress is an event rather than a chronic condition (McLoyd, 1990, p. 333). Moreover, the support relationships themselves may be sources of stress. The relatives, friends, and neighbors of poor families are themselves likely to be poor, stressed, and also in need of material and emotional support. Reciprocity in relationships is key, but not reciprocity that mutually overwhelms.

Child Outcomes. There was no observable relationship between dimensions of social support perceived by the mother and child outcomes on either the Early Screening Inventory (ESI) or the Child Behavior Checklist (CBCL). Perhaps this is because of the apparent lack of relationship between perceived social support and maternal depression. If, as McLoyd (1990) has suggested, the mother's psychological functioning is a major mediator of the effects of poverty on children's socioemotional behavior, then it is consistent that a variable shown not to have an impact on maternal depression would also not be related to child functioning.

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[16] $r = .16, p < .05$ and $r = .13, p < .05$, respectively.

[17] $r = .16, p < .05$ and $r = .15, p < .05$, respectively.

[18] $r = .19, p < .025$ and $r = .12, p < .05$, respectively.

[19] $r = -.19, p = .09$.

Early childhood education, on the other hand, which was shown to be related to child outcomes -- especially on the ESI -- may not only have enhanced performance by increasing children's exposure to age-appropriate materials and activities, but perhaps it strengthened the *child's* social support network by providing the child with additional caring adults. The presence of a stable, caring adult has been shown to be a protective factor that can counteract the negative effects of stress on children (Garmezy, 1985).

USE OF SERVICES

Regardless of income, all families need services that the family system itself or members of its social network cannot provide. However, while need -- at some level of intensity -- is a constant across all groups, access is not. Economically advantaged families can buy access to most of the services they need -- from day care to health care, legal help to drug treatment. However, as income decreases, service need and service availability seem to vary in inverse proportion to each other. That is, as need intensifies in depth and scope, access becomes more problematic. For the poorest families, there simply are not enough services to go around. For example, as noted earlier, day care slots exist for not even 20% of homeless preschoolers in New York City. Waiting lists for drug treatment programs are on the order of six to nine months; almost no slots exist for pregnant women. Nationally, WIC only serves 60% of all those eligible.

Families' knowledge and perceived need of, as well as access to and use of a broad range of, services in a number of key domains were examined. Table 15 summarizes the extent to which families said they used a particular service over the past 12 months, or, for families who were homeless, since they had been homeless. As can be seen, health care for the target child (including prenatal care) and access to WIC were the services with the highest reported usage. Next highest was adult health care, followed by early childhood education (either day care or Head Start) for the target child.

The high reported use of these services, especially for the housed families, may have been an artifact of our sampling strategy, which included two WIC programs as recruitment sites. WIC eligibility begins in the prenatal period and includes regular health check-ups to determine continued eligibility. Thus, recruitment programs may not only have inflated the level of WIC participation,

Table 15

Families' Use of Services

Services	Housed (N = 76)		Homeless (N = 84)		Homeless Prior to Homelessness (N = 84)	
	N	%	N	%	N	%
Child Services						
Child Abuse/Neglect Prevention	6	8	9	11	7	8
Day Care/Head Start (for target child)	47	62	56	67	21	25
Dental Care (for target child)	58	76	37	44	30	36
Health Care (for target child)	76	100	82	98	84	100
Infant Programs	4	5	6	7	9	11
Prenatal Care (for target child)	72	95	80	95	80	95
School-Age Recreation	21	28	21	25	11	13
Summer Camp	18	24	23	27	8	10
Adult Services						
Dental Care	56	75	39	46	55	65
General Health Care	70	92	60	71	59	70
Drug/Alcohol Treatment	2	3	9	11	8	10
Education Program	19	25	20	24	29	35
Job Training	19	25	13	16	20	24
Parent Education	8	11	16	19	8	10
Family Services						
Emergency Food	26	34	42	50	9	11
Free Clothing/Furniture	6	8	17	20	6	7
Free Meals	23	30	49	58	13	15
Legal Aid	17	22	21	25	13	15
Rehousing Assistance	N/A	N/A	57	70	N/A	N/A
Tenants Organization	16	21	8	10	9	11
WIC	72	95	62	75	64	76

Note: Percentages refer to a total sample of 76 housed and 84 homeless families. Totals do not equal 100% since families generally reported the use of more than one service.

but access to health care as well. Use of emergency food programs and free meals may also be higher in the NYFSP sample than among the general public assistance population since recruitment sites also included two food pantries. Of course, since access to early childhood education was a prime variable of interest in this study, enrollments in day care and Head Start, compared to the general population, is greatly overrepresented. Lastly, recruitment sites for housed families included a tenants organization located in a public housing project. However, not all families recruited through that site belonged to the tenants group, so it is unknown to what degree participation in tenants groups is also overrepresented.

Intensity of Service Usage. Table 15 represents dichotomous "yes"/"no" use of services. In order to take account of the number of services used, as well as to differentiate intensity of usage, a rating scale was devised which assigned differential weighting according to whether or not a service was currently being used, whether access was desired and/or had been attempted by non-users, and so on, for each service. A summary variable was then constructed which consisted of the mean of all the individual service ratings. Taking this variable as an overall indicator of service usage, it was found that housed families had a significantly higher mean use of services score than families who were homeless.[20] This was irrespective of day care enrollment, number of children in the family, mother's age, or educational level, or race/ethnicity.

Clustering of Services. The use of certain services clustered somewhat predictably. For example, use of survival-level services like emergency food, free meals, and free clothes, were positively correlated with each other. Reported use of adult-oriented services such as job training, adult education, and adult health also tended to co-occur. Although small in overall reported use, enrollment in drug treatment programs was positively correlated with use of child abuse/neglect prevention programs. Enrollment of the target child in day care or Head Start was correlated with a sibling's enrollment in summer camp, and participation by the parent in parent education and adult education programs.

However, there were no apparent relationships linking patterns of overall service usage to child and family variables. The one exception -- a significant positive correlation between the family mean use of services score and the target child's score on the Early Screening Inventory (ESI)[21] -- may well have been an artifact of day care enrollment which, as already discussed, was itself predictive of higher ESI scores.

Homelessness and Its Relationship to Service Usage

From a policy as well as program planning perspective, it is important to understand the respective roles of homelessness as a disruptor of the service relationship, and as an opportunity for needed service intervention. Sometimes it is neither. Often it is both. Families who were homeless ($N = 84$) were asked if, since becoming homeless, it had been easier or harder to access the services they needed. The majority (54%) said it was easier. When asked why this was so, respondents most frequently noted that it was simply easier to get to services; in some facilities, certain services -- like day care, WIC, parent education, free meals -- are located on-site. In addition, for many community-based services, families noted that, because they were homeless, they were given top priority for enrollment. However, 25% (*N* = 21) said it was harder: they were unfamiliar with the neighborhood; services with which they they already had a relationship were even farther away than before; they had no one to leave their children with; professionals treat people who are homeless with less respect and are less helpful. Twenty percent (*N* = 17) said becoming homeless had made no difference in their access to services; it was the same as before. Consistent with families' assessments, as indicated in Table 15, for the majority of services surveyed, a higher proportion of families reported using them while living in the shelter system than before.

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[20] $t(60) = 2.41, p < .05$.

[21] $r = .37, p < .05$.

Moreover, in comparison to families who were housed, homeless families were less linked to services prior to becoming homeless than currently housed families. Table 15 shows that, comparing service usage rates for homeless families prior to homelessness with rates among currently housed families, service usage was at approximately the same rate for four services, greater for homeless families (when they were housed) for three services, and greater for currently housed for the remainder. In summary, the currently housed families were the best linked to services. This is compared to homeless families -- not only while they are living in the shelter system, but even when they were living in the communities. Although it again must be cautioned that the service usage rates among the housed sample may be overly high due to the nature of the sampling strategy, nonetheless for a sizeable number of homeless families, service usage improved upon the families' entry into the emergency shelter system.

Barriers to Service Usage

When asked about barriers to services, answers that families gave are of no surprise: delays, bureaucratic run-around, uncaring or incompetent caseworkers (who, in many instances, are a family's entry to services), poor outreach (families reported not knowing about some of the services they were asked them about), transportation problems, and not enough slots or spaces.

Other research has also documented a cold, unresponsive service system. In a study of adolescent mothers' use of community health services, Crockenberg (1987) found that health professionals were often perceived as unsympathetic, impatient, disapproving, uninformative, and unsupportive of existing patterns of parenting behavior. This same study found little impact of service usage on parental and psychological functioning -- perhaps because of the interpersonal barriers created by the service providers. Dail (1990), in a study involving 53 homeless families living in the Southwest, found that many of the women expressed "grave disdain" for the welfare system, because of it being so difficult to use effectively. Indeed, Dail found that, in response to systemic barriers, many families had given up trying to get certain benefits for which they were eligible. Some would like to believe this is indicative of increased independence by families. To the contrary, it is probably more suggestive of increased vulnerability. In short, many families are simply not getting anywhere near the kind of support they need.

SUMMARY AND CONCLUSION

> Social researchers are subject to an ethical code that prohibits them from exposing children to situations that are injurious to their welfare. Unfortunately, there is no such restriction on the nation as a whole, and its duly empowered leaders and policy makers. The latter are free to run their economic and social experiments without such niceties as prior parental consent or review by qualified professionals. It remains the responsibility of researchers, however, to monitor these experiments and give early warning of any unintended effects. In doing so, we must use the best scientific methods at our command. There may be some difficulties in finding matched control groups, but there should be no problem with sample size. It is the irony and limitation of our science that the greater the harm done to children, the more we stand to learn about the environmental conditions that are essential for making -- and keeping --- human beings human. (Bronfenbrenner & Crouter, 1983, p. 401)

The present study was designed to explore the relationships among child development, family functioning, support services, and the conditions of chronic poverty and homelessness. The implicit hypothesis was that the chaos and instability of homelessness would exacerbate the already damaging consequences of chronic poverty.

The major finding of this study was just how few differences were found between homeless families living in shelters and hotels, and low-income families, used as a comparison group. By no means does this suggest that homelessness is not a potentially devastating experience. Rather, it speaks to the profound toll that poverty takes. Irrespective of housing status, many of the children and families in this study had compelling needs that were not being met.

SUMMARY

Sample

The sample for this study was comprised of 160 3-, 4-, and 5-year-olds and their families: 84 families were homeless and living in New York City emergency shelter facilities; 76 were situated in some kind of permanent housing, but dependent on public assistance for support. With a larger sample, it is possible that more differences between groups may have been documented. A sample of this size also meant that certain sub-group analyses could not be done since cell sizes got too small. There was not enough variation within the sample to examine fine distinctions or inter-relationships with other variables. On the other hand, those effects that were statistically significant are strong effects.

Demographic Profile

The homeless and housed women we interviewed for this study were similar in many ways. Where the two groups differed most were on those characteristics that might help to explain their vulnerability to homelessness. Women who were homeless were significantly less likely to have attained a high school diploma or GED, significantly less likely to have any work experience, and significantly more likely to have been on public assistance while growing up. They were also slightly younger on average, and had more children. Each of these variables contributes to reduced options and lessened likelihood of economic independence. Combined with housing instability, these variables may assume critical proportions. Indeed, in their present situations, families who were homeless had experienced more housing instability in the past two years (for some, but not all, an obvious artifact related to homelessness).

Child Outcomes

Developmental Status. On overall child development, as measured by the Early Screening Inventory, neither group of children -- housed or homeless -- did well. They were virtually indistinguishable from each other. Neither housing status, nor sex of child, nor family demographics (race/ethnicity, maternal age or educational level, family size) had an influence on the developmental screening score. The only variable that had an impact on outcome was exposure to early childhood education. Even children with as little as three months of exposure to Head Start or publicly-funded day care did better on the ESI than children who lacked such exposure. They had higher mean scores, and a higher percentage of them scored at a level presuming normal development. However, even while this was so, early childhood education was not enough to overcome the cumulative effects of chronic poverty. At every age-break, the children in the NYFSP sample did notably worse than the participants in a national standardization study. Overall, both groups were about a year behind the level of development that would ordinarily be expected for children their age.

Child Behavior. On day-to-day emotional adjustment, as manifested in concrete behavioral problems (withdrawal, anxiety, aggression, tantrums, sleep disorders, eating problems, bed wetting, etc.), homelessness had an observable impact. Compared to the poor housed children, a significantly higher proportion of children who were homeless had scores above the clinical cut-off on the Child Behavior Checklist, indicating the need for mental health intervention. One-third of the homeless 4- and 5-year-olds, compared to 11% of a group of domiciled peers, exhibited behaviors of a serious enough nature and frequency to suggest the need for further psychiatric assessment.

Child Health. Finally, neither group was in the best of health. Children who were homeless experienced higher rates of certain acute conditions, such as diarrhea, upper respiratory infections, and ear infections. However, both groups had equally high rates of low birthweight and similar rates of chronic conditions like asthma and anemia.

In short, based on the outcomes from the health, behavioral, and general developmental indicators used in this study, these young children -- irrespective of housing status -- are greeting their futures at considerable disadvantage. Unless major features of their life experience change dramatically, achievement of future success will be an uphill struggle. The children we met were streetwise, cautious, yet eager to learn. Many exhibited characteristics -- a sense of humor, enthusiasm, persistence -- that, if not extinguished, will help to buffer them against the stresses in their lives, by eliciting from caring adults the extra attention and positive reinforcement that they need. But, at the same time, they were burdened; some by poor health, almost all by life conditions in which survival itself is an accomplishment. Bereft of the opportunities and experiences available to more economically-advantaged children, and compromised by health problems, many are behind before they start. And without special supports and intervention -- like access to adequate health care and high quality early childhood education -- they are in danger of falling even further behind.

Family Outcomes

Maternal Depression. Both housed and homeless families evidenced equally serious manifestations of the daily frustrations, anxieties, and sense of helplessness that profound poverty imposes. Irrespective of housing status, the women who participated in this study reported an alarmingly high rate of referable depressive symptomatology, as measured by the Center for Epidemiologic Studies (CES-D) Depression Scale. Forty-two percent of the women who were homeless and 40% of the housed women scored at or above the cut-off score, indicating a need for referral for further psychological assessment.

Significant Life Events. The Norbeck Life Events Questionnaire was used to record significant positive and negative life events that families had experienced in the 12 months prior to being interviewed. Families who were homeless experienced an average of nine significant life events over the course of the past year, compared to seven for families who were housed, and one to two per year reported in community surveys among the general population. For the full sample -- housed and homeless alike -- there was a significant positive correlation between the number of negative life events which mothers reported and their level of depressive symptomatology, as measured by the CES-D scale.

Although the effects of chronic life conditions were not specifically addressed in the present study, it was clear that they had a huge impact. Looking only at "events" necessarily constricts the range of vision. For instance, even homelessness cannot fairly be considered an "event" when it lasts for an average of 12 months, as it did for the participants in the present study. Moreover, the effects of the event that precipitate an episode of homelessness (eviction, fire, abuse), combined with the events that usually accompany the onset of homelessness (leaving a neighborhood, changing schools, losing possessions, disrupting social networks), and the ongoing conditions of homelessness (violence, isolation, instability), extends in impact far beyond what would be represented in the coding of a single "event" of homelessness.

Social Supports. In general, there were no differences that distinguished families who were homeless from families who were housed in terms of the composition and characteristics of their social networks, as measured by the Norbeck Social Support Questionnaire (NSSQ). Neither housed nor homeless families had very large networks. One of the key findings was the major role that children played in providing their mothers with emotional support. Overall, both groups were quite isolated and did not appear to have many social resources that could buffer -- either emotionally, or through the provision of direct aid -- the impact of the stresses in their lives.

Use of Services. Families' knowledge of and perceived need of, as well as access to and use of, a broad range of services in number of key domains were examined. Partially as a result of recruitment strategies, health care and access to WIC were the services with the highest reported usage. Next highest was adult health care, and access to early childhood education (also a function of recruitment strategy). In comparison to housed families, homeless families were less linked to services -- both currently, as well as prior to becoming homeless. In fact, the majority of homeless families found accessing services to be easier than it had been before they entered the shelter system. In many cases, services were located on site. Nonetheless, both groups complained about barriers to services, including delays, bureaucratic run-around, uncaring or incompetent caseworkers, poor outreach, transportation problems, and not enough slots or spaces.

A FALSE DICHOTOMY

Although children who were homeless responded with a higher incidence of problem behaviors and experienced a higher rate of certain acute diseases, and mothers spoke of the intense stress and loneliness associated with shelter living, in the end, the data did not significantly differentiate between the two groups to whose lives we were introduced. We can only conclude that it is poverty that produced the results of this study.

Indeed, take away the name of the housing -- call it "permanent" or "temporary;" a "shelter" or a "city-owned building" -- and, in certain respects, the daily lives of both groups of families did not seem all that different. The lives of the housed families were not necessarily safer, more predictable, less violent, less fearful. Twenty-eight percent had themselves been homeless; the 30% who admitted to being doubled-up (one-quarter of whom were formerly homeless) were at high risk of homelessness. As much as can be determined, both groups of families were sampled from the same population. Although the homeless families had a few more cards stacked against them -- as a group, they were younger, had less education, less work experience, more children, and a longer history of public assistance -- examination of individual case histories made it difficult to see why this family and not that one lost their housing. Especially in the case of evictions and fires, to a large extent the precipitating events of homelessness seemed arbitrary. Perhaps this is one reason so few differences were found between the housed and homeless families.

Research suggests that "it is the number or combination of risk factors, rather than their nature that is the best determinant of outcome" (Sameroff, et al., 1987, p. 343). For children, it is the cumulative effect from multiple risk factors that increases the probability of negative developmental outcomes. Poverty, alone, is already associated with multiple risk factors: single-parent status, low maternal education level, stressful life events, chronic life conditions, psychological distress. For children in this study, minority status was another risk factor. Homelessness was but one more.

In addition, the mutual exclusivity suggested by terms like "housed" and "homeless" implies what is actually a false dichotomy. To illustrate: Lisa Danville, age 28, was "homeless." In the 24 months prior to being interviewed for this study, she and her three children had moved three times. Their nine months in the Tier II shelter, where they were living at the time of the interview, had been preceded by two months in a Tier I congregate shelter, seven months in Lisa's mother's apartment, and six months in her boyfriend's mother's apartment. Ms. Danville defined homelessness just like the City bureaucracy does -- the length of time spent in the emergency shelter system. Thus, she did not consider those periods of being doubled-up as being homeless. In the end, though, it is difficult to distinguish precarious, highly mobile, non-independent housing from homelessness. The nine months Lisa and her children had spent in the Tier II shelter were the longest they had lived in any one place in well over two years. Moreover, there were services on site. Her son was enrolled in day care; he hadn't been prior to becoming "homeless."

The housing status of certain segments of the population is actually quite fluid, changing from homeless to housed to homeless again, a process which Sosin et al. (1990) have called repeated "weak exits" from the system. For example, Melissa Smith, also 28, moved five times in a 21-month period. First, she and her two children left the apartment in which she was the primary tenant because of an abusive partner. From there, the family spent one month in a Tier I congregate shelter, and six months in a welfare hotel, before moving in with her mother. However, this arrangement lasted only seven months. Then, a one-month stay in another Tier I shelter was followed by seven months in a Tier II shelter. When she was interviewed, Ms. Smith was still in the shelter and looking for a permanent apartment.

Of course, one's phenomenological definition of the situation counts. It contributes to one's perceived level of hope or despair. Loss of housing has been compared to bereavement (Marris, 1974). However, whereas bereavement acknowledges grief through the establishment of mourning customs, which gradually mark the stages of re-integration into daily life and routine after an initial period that includes a moratorium on other activity and a specific focus on the personal loss, there is no place for grief in homelessness as American society now responds to it. For the most part, society has embraced a largely punitive response expressed through rigid, sometimes harsh, bureaucratic procedures intended to create disincentives for losing one's shelter. When asked about the impact of homelessness on themselves, the majority of respondents referred to stress and depression and their concern for its impact on their children. Nevertheless, some (9%) felt it was not much different from before, and 16% viewed it as a positive crisis. These women said things like, "It has helped me face up to responsibility." "It taught me a lesson. It made me strong." "It makes you thankful for what you got."

CONCLUSION

A growing number of observers and analysts caution that homelessness -- and the conditions that give rise to it -- may now pose the single greatest threat to our national well being, either from within or without (Edelman, 1987; Schorr, 1988; Ford Foundation, 1989). Congressman George Miller of California, who has taken an especially active interest in the plight of the homeless, terms it simply, "a national tragedy," one which threatens the very foundations of our country. According to a recent report issued by the Ford Foundation (1989), that threat is framed by the larger phenomenon of chronic poverty, which now poses dire consequences for our entire national economy in terms of: a rapidly eroding competitive labor base; the overwhelming economic burden that will be placed on our welfare/social service systems by those children currently growing up in poverty; and the dwindling ratio of workers to social security recipients. At the end of 1989, following a seven-year period considered one of economic recovery, one in five American children lived in poverty (*CDF Reports*, 1990). In that same year, the U. S. Conference of Mayors (1989) reported that families with children were the fastest growing segment of the homeless population. Since then, the country has slid into an economic recession. Many believe the problem of homelessness will only get worse, as a result. There is an ever louder call for a federal response to what is increasingly being seen as a federal problem.

There would, perhaps, be little cause for alarm if current efforts to address the situation were making any meaningful inroads at the nationwide level. But they are not (cf Kryder-Coe, Salamon, & Molnar, in press). The principal features of our welfare system were cast in the 1930s and have changed remarkably little since then, while the character of society, by any measure, has changed greatly. Coupled with macroeconomic forces that have at one and the same time considerably reduced the real value of public assistance dollars (McChesney, in press) while exponentially increasing the cost of living index -- including housing -- the entrenched nature of our welfare structures has resulted in a fragmented, badly underfunded service net through which the poor now routinely fall. The immediate cost in human terms is appalling, especially for children, who are inevitably most vulnerable to the vicissitudes of society.

Although the present study was local, its impact is national. Adding the results to the existing literature confirms what many people seem to have suspected for a while: (1) homelessness is bad news for the homeless, (2) however, it is not just homelessness *per se*; shelter alone is not adequate protection against the ravages of poverty, and (3) those socioeconomic forces contributing to the unchecked growth of both homelessness and poverty may be bad news for us all of us down the line. Basic, documentary research, of course, is essential, but it is just a first step; the next level of research needs to address those questions and issues most salient to welfare and housing reform because, if our society is to avoid permanent damage to a whole generation of homeless and chronically poor children, it must act quickly and cogently in these areas.

RECOMMENDATIONS

Recommendations that come from the research presented here are almost self-evident:

Early childhood education was the single variable that made a difference in the developmental profile of the children who participated in this study. There is an urgent need for access to early childhood education programs for all disadvantaged children, especially homeless children.

> **Recommendation 1:** Every effort must be made to secure the resources for necessary expansion of publicly-funded day care and Head Start to all eligible children.

Irrespective of housing status, maternal depression was a potentially serious problem for 40% of the women interviewed as part of this study. Maternal depression has serious implications for both family functioning in general and children's development in particular.

> **Recommendation 2**: Creative outreach strategies must be developed in order to engage families and provide them with the support they need. However, mental health issues must not be addressed outside of the larger context of poverty and housing. Systemic long-term strategies (e.g., massive job training efforts, widespread expansion of child care services, commitment to accessible low-income housing) must be pursued in tandem with more immediate mental health intervention.

Schorr (1988, pp. 256-259) described attributes of programs that work. Included among them:

- Successful programs "see the child in the context of family and the family in the context of its surroundings" (p. 257). By definition, then, successful programs typically offer a wide variety of services with, if not an explicit then an implicit, recognition of families' hierarchy of needs. That is to say, the most fundamental human needs for food, clothing, and shelter preempt all else. The hierarchy of needs builds from there. For example, 95% of all NYFSP respondents wanted a job. However, other needs came first. Mothers mentioned the need to take care of their young children as the key thing preventing them from being employed. The need for child care rivaled the need for more education and/or job training. Among homeless families, the need for housing was mentioned as often as the need for education and job training.
- Service providers in successful programs care about and respect the people they serve. Although both groups of NYFSP families complained about the unhelpful attitudes of program staff, homeless families specifically mentioned the discrimination and disdain they frequently encountered.
- Programs that work are coherent and easy to use. In contrast, long lines, complicated forms, incomplete and ill-timed information, in short, the perception of bureaucratic runaround dominated the litany of complaints about services in New York City.

Recommendation 3: Services must be comprehensive and flexible. They must properly view parents and children as part of a unit, and they must afford all individuals they respect they deserve.

Related to this: Families' needs exist along a continuum. Some families only need housing. Others need job training and day care so they can afford to maintain their housing once they get it. Still others need intensive intervention -- health care, drug treatment, mental health services, and the like, in addition to job training and day care -- to be able to successfully stabilize and subsequently manage independent living.

Recommendation 4: Services need to be tailored to the special needs of individual families.

The importance of concentrating primary services, coupled with aggressive outreach and a basic case management approach, both in emergency shelter systems, and in neighborhoods with poor, at-risk populations cannot be overstated (Notkin, et al., 1990).

> **Recommendation 5:** Innovative program structures, supported by funding mechanisms that cut across bureaucratic boundaries, must be developed and supported.

> **Recommendation 6:** So long as emergency shelter facilities are necessary, the need for specially designated shelters for families with children should be designed to accommodate these families from onset of homelessness through relocation to permanent housing.

Wacquant & Wilson (1989) described the process of hyperghettoization that is occurring in our inner cities as the level and concentration of poverty intensifies. In New York City, many formerly homeless families are being relocated to neighborhoods that were essentially abandoned well over a decade ago, and thus lack the most basic of services, such as schools, hospitals, churches, even grocery stores.

> **Recommendation 7:** Resources must be allocated for rebuilding the community-level social service infrastructure. Related to this, the concept of service-enriched housing should be actively explored and piloted.

For homeless families -- as well as precariously-housed families -- the bottom line continues to be safe, decent, and affordable permanent housing.

> **Recommendation 8:** All efforts must be made to muster the political will necessary to make available the billions of federal dollars that are needed to produce enough low-income housing units for all who need them.

* * *

In the end, what most highlights the similarities between the housed and homeless families were the answers mothers gave to the open-ended set of questions that concluded NYFSP's interview protocol. Broadly, the women were asked to assess their hopes, expectations, and plans for the future. The same themes emerged over and over, the most poignant of which, perhaps, was the repeated expression of hopes for a better life for their children and themselves. An overwhelming number of mothers expressed a desire to continue or complete their educational careers and enroll in some kind of job training, as soon as their children were old enough to attend either school or day care.

Perhaps, the most notable feature of the responses to these open-ended questions is how deeply rooted they are in what is classically construed as the "American Dream": financial security; stable employment; a decent home; and happy, healthy children. Although, cumulatively, the dominant pattern that emerged from the data suggest a bleak future for most of the families we interviewed -- housed and homeless alike -- it is important to note that their hopes and ambitions paint a distinctly different picture. In spite of everything, these families did not feel helpless and defeated. The opportunities this stubborn optimism invites must not be ignored.

Epilogue

Ill fares the land, to hastening ills a prey,
Where wealth accumulates and men decay;
Princes and lords may flourish or may fade;
A breath can make them as a breath has made;
But a bold peasantry, their country's pride,
When once destroy'd, can never be supplied.

from **The Deserted Village**
Oliver Goldsmith

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Appendix A

Homeless Sample Temporary Shelters

Appendix A

Homeless Sample Temporary Shelters

Tier II Facilities & Family Centers (N=59 families)
- American Red Cross Emergency Family Center
- Convent Avenue Shelter
- Harriet Tubman Family Living Center
- (Unnamed) battered women's shelter

Hotels (N=25 families)
- Allerton Annex
- Hamilton Place Hotel
- Madison Hotel
- Prince George Hotel

Housed Sample Recruitment Sites

Early Childhood Education (ECE) Group (N=38)
- Children's Aid Society Frederick Douglas Children's Center (Head Start)
- Hudson Guild Day Care
- West Harlem Head Start Program

Non-ECE Group (N=38)
- Columbia University Community Impact Program (Emergency Food & Clothing)
- Grant Houses Tenant Association
- Riverside Church (Emergency Food & Clothing)
- William F. Ryan Health Center WIC Clinic

Pilot Site

Bloomingdale Family Program (Head Start)

Appendix B

Early Screening Inventory (ESI) Cutoff Scores by Age Group

Appendix B

Early Screening Inventory (ESI) Cutoff Scores by Age Group

Age Group	Refer	Rescreen	OK
3-0 to 3-5	<9	9-13	>13
3-6 to 3-11	<15	15-17	>17
4-0 to 4-5	<11	11-15	>15
4-6 to 4-11	<13	13-17	>17
5-0 to 5-5	<16	16-20	>20
5-6 to 5-5	<18	18-22	>22

Note: Range is 0 - 30.

Appendix C

Child Outcomes on the Early Screening Inventory (ESI)
Mean Scores by Age Group by Housing Status

Appendix C

Child Outcomes on the Early Screening Inventory (ESI) Mean Scores by Age Group by Housing Status

	Housed (N = 63)			Homeless (N = 76)		
Age Range	**N**	**Mean**	**S.D.**	**N**	**Mean**	**S.D.**
3-0 to 3-5	3	14.7	5.9	11	11.7	3.8
3-6 to 3-11	19	17.4	4.6	15	15.8	6.2
4-0 to 4-5	16	17.2	4.9	15	16.5	5.0
4-6 to 4-11	17	18.9	5.0	17	17.8	4.6
5-0 to 5-5	8	18.6	6.3	14	22.4	3.8
5-6 to 5-11	0	–	--	4	25.8	3.9

Note: Since unscorable ESIs (3 or more refusals) are not included, the sample size = 139.

Appendix D

Child Outcome Data Sample Sizes

Appendix D

Child Outcome Data
Sample Sizes

Measure	Homeless	Housed	Total
Early Screening Inventory (ESI)	70	81	151
ECE	42	50	92
No ECE	28	31	59
ESI--excluding unscorables	63	76	139
ECE	38	47	85
No ECE	25	29	54
Child Behavior Checklist	76	83	159
3-year-olds	30	31	61
4- & 5-year-olds	46	52	98

Appendix E

Child Outcomes on the Early Screening Inventory (ESI) Mean Scores by Age Group by Access to Early Childhood Education (ECE)

Appendix E

Child Outcomes on the Early Screening Inventory (ESI) Mean Scores by Age Group by Access to Early Childhood Education (ECE)

	ECE (N = 85)			No ECE (N = 54)		
Age Range	N	Mean	S.D.	N	Mean	S.D.
3-0 to 3-5	6	13.7	3.7	8	11.4	4.6
3-6 to 3-11	20	17.8	4.2	14	15.0	6.5
4-0 to 4-5	19	16.8	4.9	12	17.0	5.0
4-6 to 4-11	22	18.7	4.9	12	17.7	4.7
5-0 to 5-5	14	21.7	6.1	8	19.9	2.5
5-6 to 5-11	4	25.8	3.9	0	--	--

Note: Since unscorable ESIs (3 or more refusals) are not included, the sample size = 139.

Appendix F

Histogram of Center for Epidemiologic Studies Depression Scale (CES-D) Total Scores

Appendix F
Histogram of Center for Epidemiologic Studies Depression (CES-D) Scale Total Scores

Homeless (N = 84)

0	------ 1
1	------ 1
2	------ 1
3	-- 6
5	-------------------------- 3
6	--------------------------------- 4
7	------ 1
8	--------------------------------- 4
9	-------------------------- 3
10	------ 1
11	-- 6
12	--- 5
13	--------------- 2
14	--------------------------------- 4
15	-------------------------- 3
16	--- 5
17	------ 1
18	------ 1
19	--------------------------------- 4
20	--------------------------------- 4
21	--- 5
22	------ 1
24	-------------------------- 3
25	------ 1
26	------ 1
29	--------------- 2
32	------ 1
33	------ 1
34	------ 1
35	------ 1
38	------ 1
39	------ 1
42	------ 1
43	--------------- 2
47	------ 1
48	------ 1
I	.....................I.....................I.....................I.....................I
0	2 4 6 8

Number of Respondents

Housed (N = 76)

0	---------------- 2
1	--------------------------------- 4
2	------- 1
3	------- 1
4	--- 5
5	-------------------------- 3
7	-------------------------- 3
8	-------------------------- 3
9	---------------- 2
10	-------------------------- 3
11	-------------------------- 3
12	-------------------------- 3
13	-------------------------- 3
14	---------------- 2
15	--------------------------------- 4
16	---------------- 2
17	-- 6
18	---------------- 2
20	-------------------------- 3
21	------------------------ 3
22	-------------------------- 3
24	---------------- 2
25	---------------- 2
27	---------------- 2
28	------- 1
29	------- 1
30	------- 1
36	------- 1
37	------- 1
38	------- 1
40	------- 1
41	---------------- 2
I	.....................I.....................I.....................I.....................I
0	2 4 6 8

Number of Respondents

* Referral cutoff point: A score of 16 or higher indicates the need for referral for further psychological assessment.